

HIV/AIDS IN AFRICA: STEPS TO PREVENTION

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HIV/AIDS IN AFRICA: STEPS TO PREVENTION

WEDNESDAY, SEPTEMBER 27, 2000

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON AFRICA,
COMMITTEE ON INTERNATIONAL RELATIONS,
Washington, DC.

The Subcommittee met, pursuant to call, at 2:20 p.m. in Room 2172, Rayburn House Office Building, Hon. Ed Royce [Chairman of the Subcommittee] presiding.

Mr. ROYCE. This hearing of the Subcommittee on Africa will come to order. Today, the Africa Subcommittee will look at HIV/AIDS, the pandemic in Africa. Particularly we will look at steps that can be taken to prevent its spread. The HIV/AIDS crisis has taken a devastating toll on Africa. An estimated 16 million Africans have died from HIV/AIDS. Two-thirds of the HIV-infected people worldwide, that is some 30 million people, are in sub-Saharan Africa. It is estimated that over the next 20 years AIDS will claim more lives than all the lives of the wars in the 20th century. HIV/AIDS is damaging to Africa's economic development. It absorbs sparse resources. It strikes down people in their prime of life. It destroys social cohesion. The AIDS epidemic is having an alarming impact on children in Africa. AIDS orphans run a greater risk of being malnourished or of being abused and, of course, being denied any education, and because of women's lack of economic and social power, Africa is the only region in the world in which women are infected with HIV at a rate higher than men.

AIDS is ripping apart African families while harming political stability and harming democratic development in Africa.

As the Namibian Secretary of Health has written, prevention is the only weapon that will effectively halt the HIV/AIDS epidemic. There is no doubt prevention efforts must overcome significant cultural, educational and resource challenges, but the battle can be won. Progress demands a political commitment on the continent. President Yoweri Museveni of Uganda has raised the issue of AIDS in virtually every speech he has ever given in public since 1986. With this commitment, including support for anti-AIDS village education projects that I have witnessed, Uganda has made impressive strides in reducing its HIV infection rate.

Part of Uganda's success can be attributed to the support of its relatively vibrant civil society backed by private sector entrepreneurs.

By contrast, President Robert Mugabe of Zimbabwe has barely uttered a word about AIDS in his 20 years in power. AIDS is devastating Zimbabwe.

There is no question that the U.S. should be doing more to address the AIDS crisis in Africa. This means committing more resources, and I want to commend my colleague Barbara Lee of the Subcommittee for the work she has done in this regard.

I also wanted to share with you that we are videoconferencing with one of our witnesses today in South Africa, and we are Web casting so that people from anywhere in the world can look in and follow this dialogue and hear this debate, and I would just like to share the way to do that and that is www.house.gov/international_relations, and that will allow you to pick up the Web site.

At this time, I would like to turn to my colleague Congresswoman Barbara Lee, to ask her if she would like to make an opening statement before we go to our first panel.

[The prepared statement of Mr. Royce appears in the appendix.]

Ms. LEE. Thank you, Mr. Chairman. I want to thank you for conducting this hearing and for once again focusing our attention with regard to the pandemic of HIV/AIDS in Africa. Today's hearing is another example of the attention that the AIDS crisis is gaining in the Congress and we are forcing the idea that Africa truly does matter.

I would also like to thank all of our hearing participants for joining us today and for offering their testimony to help us focus our efforts to learn how to prevent HIV/AIDS. It is also extremely important to note that the global AIDS crisis also forces us to reevaluate our public health policy by including more profound steps to bring a balance between prevention and education and treatment and care. HIV/AIDS continues to wreak havoc in Africa but once again, as we have said so many times, Africa is unfortunately the epicenter of this disease.

The World Health Organization has proclaimed that HIV/AIDS is the world's deadliest disease. We see now India and Southeast Asia and Eastern Europe and other parts of the world becoming victimized by this deadly disease. Yet in a Washington Post article it was revealed that while our intelligence agencies and our government knew about this as early as the 1990's, we really didn't do much. We chose to sit on our hands. So now the survival of a continent is at stake. So we must continue to beef up our attention to put more resources into this pandemic.

In July, I was privileged to have traveled to the International AIDS Conference in Durban, South Africa, and the thing at that conference was breaking the silence. For many of the participants at that conference it also served as a message of hope, breaking the despair.

These hearings, Mr. Chairman, really do allow us to continue to break the silence here in Washington, DC.

I have a report from my visit to the Durban Conference and it would be available for anyone who would like to look at what we concluded and found.

Mr. ROYCE. And we will put that into the record.

Ms. LEE. Thank you, Mr. Chairman.

Mr. ROYCE. Without objection.

[The information referred to appears in the appendix.]

Ms. LEE. With that, I will stop now and look forward to the participants here today and want to thank you again for this.

Mr. ROYCE. Thank you, Congresswoman.

Our first panel—we have just been joined by the Vice Chairman of the Subcommittee, Amo Houghton—we will now go directly to our first panel.

Miss Vivian Lowery Derryck has been the Assistant Administrator for Africa with the U.S. Agency for International Development since July 1998. Prior to joining AID, she was Senior Vice-President and Director of Public Policy at the Academy for Educational Development, a U.S.-based private voluntary organization.

Ms. Derryck has worked in more than 25 countries, in Africa, Asia, South America and the Caribbean, including 4 years teaching at the University of Liberia. She has also served as a Deputy Assistant Secretary of State.

Mr. Sanford Ungar has been the Director of the Voice of America since June 1999, overseeing 900 hours a week of VOA broadcasts in English and 52 other languages which reach 91 million people around the world.

Prior to joining the VOA, Mr. Ungar was the Dean of the American University School of Communications for 13 years.

Mr. Ungar has had a distinguished career as a print and broadcast journalist, including a stint as the Nairobi correspondent for Newsweek. He has written a number of books, including *Africa: The People and Politics of an Emerging Continent*. VOA and Radio Free Asia, I might add, are very important foreign policy tools.

Ms. Derryck, if you would commence, and since we have your written testimony, we would ask you both to just summarize your testimonies within the scope of 5 minutes. Thank you.

STATEMENT OF VIVIAN LOWERY DERRYCK USAID—ASSISTANT ADMINISTRATOR, AFRICA BUREAU

Ms. DERRYCK. Thank you very much, Mr. Chairman, and thank you for holding this hearing. HIV/AIDS is one of the gravest threats to the global community and certainly it is the development challenge for Africa.

In this oral testimony I will focus on prevention because my remarks have been summarized for the record, but I do want to make a few observations before getting to prevention. First of all, just to underscore the fact that HIV/AIDS is a long-term issue, and we are going to have this problem with us for many, many years, as the number of those infected and the number of deaths indicate; and plus the fact that there is no vaccine in sight.

Secondly, HIV/AIDS affects absolutely every aspect of a developing country from GDP to education and, therefore, for us at USAID it requires multisectorial responses. Thirdly, responses to the pandemic have to be regional because the disease knows no boundaries. So we cannot work in Swaziland and not work in Lesotho. We can't work in South Africa and not work in Botswana. So for us, it is important as well that we have a regional approach.

Fourth, as you said, Mr. Chairman, the disease differentially impacts women, but for us this is a major, major area of concern because about 55 percent of all new infections in Africa occur among women, and the vulnerability of the disease is especially high

among young girls because they have the lack of education, inadequate access to information and other generally lower economic and social status.

Lastly, the only hope that we have at the moment to stem the scourge is prevention, and that is going to be the focus of my remarks. I, too, was in South Africa for the Durban Conference with Congresswoman Lee, and the bulk of my remarks will be based on my observations there.

We know that we need to really focus on prevention and behavioral change. We know that preventing infections and thereby protecting the 70 to 80 percent of the population that is not yet infected should be our highest priority. And it is important to remember that, that the proportion of the populations that are not yet infected is very, very high. It is as high as 95 to 99 percent in a number of West African countries and our effort should be to make sure that those numbers remain just where they are.

Successful prevention programs incorporate a set of interventions, and there are about five of them. Better availability of information, condoms and social marketing, mother to child transmission prevention, voluntary counseling and testing and access to support services for persons that are infected.

All this means that we have to have broad multisectorial approaches to the epidemic.

But prevention requires behavioral changes, and one change that we have advocated is increased use of condoms, and in Africa we see that this is really making a difference. So that is one prevention area.

Our social marketing programs have been increasingly effective over the past years and sales have really soared. On the whole, more men report using condoms than women and both sexes are more likely to use condoms for sex with casual partners. But female condoms are an added measure that women can undertake to protect themselves. Female condoms aren't meant to replace male condoms but rather their availability increases the options available to women to protect themselves.

I just underscored the point that I made earlier about the need to really think about women and ways to protect them because they are differentially impacted. USAID is also very much involved in a second preventive strategy, and this is one that we highlighted a lot at Durban, and that is voluntary counseling and testing.

UNAIDS estimates that 90% to 95% of Africans don't know their HIV status. The availability of voluntary counseling and testing will increase access to information and services that will inform Africans of their status, whether they are sero-positive or sero-negative. I talk about VCT as faster, quicker, cheaper. It is faster because it is just a finger prick. It is quicker because you find out your status in 45 minutes rather than having to come back in 10 or 12 days, and it is cheaper at \$1 to \$2 per kit, and with the surround of counseling the cost is about \$12 to \$24 per person and that is a dramatic decrease, and we think that that is really very, very promising.

Another intervention that we are focused on is MTCT, trying to reduce mother to child transmissions. That is responsible for 10 percent of all new infections in Africa. Because multiple factors in-

fluence transmission of HIV from parent to child, USAID is supporting a broad set of interventions to prevent MTCT, but we think that carefully implementing these programs has the potential of not only saving the lives of infants but also serving as a catalyst for improving and expanding HIV prevention and care services.

MTCT is really a very complex intervention to deliver. We are trying to support a set of interventions that include training of health workers, providing the VCT services so that the mothers know their status; providing the drugs in some cases and developing community-based support systems for women and their children.

We are trying to work in a situation in which we can reduce the stigma and that is really one of the complexities of MTCT, because in many communities breast feeding is the norm and to be seen giving breast milk substitutes or formula discloses one's status and brings a whole set of social issues. We know what happened in the case of disclosing status with Gugi Dlamini in South Africa, which was featured at the Durban conference.

Mr. Chairman, I mentioned that this is a long-term problem and nothing better illustrates that than the demographics on orphans, and that was the second major finding that occurred for us from Durban. This epidemic is producing orphans on a scale that is unrivaled in world history.

Forty million children are estimated to become orphans by 2010 from all causes, but new statistics indicate that that number might go up to 44 million children, and the overwhelming majority of them are going to be in Africa. And these children are pressed into service for their ill and dying parents. They have to leave school. They have to help out in the household. Many of these girls are pressured into sex to help pay for the necessities for their families, and this is a major, major problem.

We visited a place, Kato Housing in Durban, and lo and behold, we were told that when they were doing surveys that they knocked on one door and they found that a 10-year-old was responsible, he was the adult, he was the household leader, and so we have seen this over and over again, and we at USAID think this is something that we have to work on. We call this the iceberg phenomenon.

We are developing a set of community-based responses to support orphans, and the USAID publication, *Children at the Brink*, which is really a seminal work, identifies five basic strategies that we will use. I am just going to mention three of them. We are going to strengthen the capacity of families to cope with these problems of orphans. We are going to mobilize and strengthen community-based responses, and we are going to work to ensure that governments protect the most vulnerable children.

We believe that the first line of defense is to enable children to be able to stay in school. Ultimately education is the key to this, so that they can acquire the skills to care for themselves and to be able to be effective, carriers of the creed that one should not engage in unprotected sex.

So in conclusion, Mr. Chairman, we believe that we at USAID have led the fight in this epidemic; we know we have since 1986. We are the largest bilateral donor for HIV/AIDS. We have technical expertise across the continent that is really unmatched.

In the past 2 years, we have increased our investment to fight this problem. The Leadership and Investment in Fighting an Epidemic, the LIFE initiative, which has been launched by the Clinton administration and handsomely supported by Congress, is a very strong acknowledgment of the pandemic and last year reflected a package of interventions that have been shown to work.

Since 1986, we have learned several lessons. One is the knowledge that you have to fight the epidemic through the involvement of senior leadership. Mr. Chairman, you mentioned President Museveni as a good example of that and hopefully we will see more and more African leaders coming to the fore. We have also learned that we can't just rely on one or two interventions to turn around the kind of epidemics that we see raging in Africa. I focused on the ones that we hope will work but we have got to focus on prevention, behavioral change, home-based care and treatment, and care for orphans and building infrastructure.

We will work with other donors to increase and coordinate support and encourage and reinforce national attention and leadership such as in Uganda and Senegal, and USAID will address this special challenge of orphans.

I thank you.

[The prepared statement of Ms. Derryck appears in the appendix.]

Mr. ROYCE. We thank you, Ms. Derryck, very much. We will go now to Mr. Ungar's testimony.

STATEMENT OF SANFORD UNGAR, DIRECTOR, VOICE OF AMERICA

Mr. UNGAR. Thank you, Mr. Chairman. Thank you to your Subcommittee and its excellent, efficient and thoughtful staff for arranging this hearing today.

I have been asked to speak about the role the media are playing in preventing and containing the spread of HIV/AIDS in Africa. We have taken a special interest in this issue at the Voice of America, as you know, given that an estimated 40 percent of our listeners now live in Africa, and I might say, Mr. Chairman, we have been very grateful for your support and for your participation in programs and conferences that we have held recently at VOA.

Confronted by the stark statistics and dire forecasts associated with most discussions of HIV/AIDS in Africa, one could easily be overwhelmed by the scope of this pandemic. Open discussion of HIV/AIDS, a frank explanation of the methods of prevention and treatment and the encouragement of social acceptance for individuals afflicted with the virus are all critical.

So is the exposure of bogus explanations for the disease's origin and of get-rich-quick quack schemes that hold out false promises of a cure. The media working in Africa have a responsibility to convey accurate information to people who may be at risk of contracting the virus, but local media in Africa are not always operating on a level playing field, particularly when it comes to coverage of HIV/AIDS. They often find themselves subject to censorship by governments still coming to terms with the scope of the virus and the catastrophic consequences it portends for their countries.

In the absence of unambiguous authoritative statements by some African leaders to break the silence and stigmatization associated with HIV/AIDS, popular misperceptions about transmission and treatment have been allowed to flourish; thus, making the media's role much more difficult to accomplish and that is why outsiders must help.

In Africa, if I may say so, radio is king, and it is often the most effective means of reaching people and generating discussion of subjects long considered taboo. At its best, radio in Africa can serve as an antidote to the dearth of reliable medical information about how HIV/AIDS is spread and how it can be prevented and treated. This must be done, even at the risk of intruding, violating the old code of silence or offending sensibilities.

I would like to describe for you a few of the ways that the Voice of America and some of its affiliate stations in Africa are working on this problem. VOA broadcasts into African homes in 11 languages every day. Let me repeat that. We broadcast into Africa in 11 languages every day. And over the past 15 years, we have made stories about HIV/AIDS a broadcasting priority. Our features on the topic have tried to help some 36 million listeners in Africa make informed choices about dealing with the disease.

VOA's programs on HIV/AIDS are not limited by any means to shortwave radio or even to medium wave or FM. The Internet and television amplify the impact and the reach of these broadcasts. Already, VOA streams nearly 70 hours of live or on-demand programs to Africa on the Internet each week. In urban areas throughout the continent, where television has begun to rival radio in popularity, VOA affiliate stations broadcast Africa Journal, a popular weekly call-in television program which has tackled HIV/AIDS related issues from many angles ever since going on the air 9 years ago. It has created the kind of space for open dialogue about HIV/AIDS that may be difficult for many African viewers to find in their own communities.

A new VOA weekly radio-television simulcast called Straight Talk Africa has just been launched and will also treat HIV/AIDS in upcoming programs. For those programs and others, including this week an English language TV news-magazine shown by several African networks and individual stations, VOA video journalists with digital cameras have learned to enhance HIV/AIDS-related stories with powerful images.

The effectiveness of information is often difficult to measure, as you know, but there are some telling signs that we have had an impact. Earlier this year, the director of Rwanda's national anti-AIDS program cited VOA Central African service for its help in raising awareness among his countrymen about the impact of HIV/AIDS on their society.

He noted that the number of Rwandans who now admit to carrying the disease has increased.

Last year, VOA joined forces with the Confederation of East and Central African Football Associations and the Johns Hopkins University Center for Communication Programs to develop a series of HIV/AIDS-related messages, public service announcements, that were recorded by soccer players and broadcast during an African soccer tournament. In addition to earning VOA an award from that

football confederation, it promoted several African sports reporters to team up to form the Association of Sports Journalists for Health in East and Central Africa. Now funded in part by a grant from Cable Positive and HIV/AIDS Awareness Foundation associated with the American cable television industry, VOA is about to embark on ambitious and innovative HIV/AIDS programming for southern Africa. Working especially with two of our affiliate stations, Bush Radio in Cape Town, South Africa, and Radio Pax in Beira, Mozambique. We will produce HIV/AIDS awareness concerts commemorating World AIDS Day in December.

Leading up to the concerts will be a series of teen town meetings with youth in Cape Town area high schools and a community-wide townhall meeting in Barea about HIV/AIDS-related issues. I am very pleased to be able to say that we just had word today that BET, Black Entertainment Television, will be joining us as a sponsor and participant in these concerts and our other efforts in this HIV/AIDS awareness program in southern Africa.

At the same time, VOA will create a radio documentary mini-series in English and Portuguese identifying certain communities in southern Africa and even particular individuals to follow over the next 2 years in order to understand better the impact of HIV/AIDS in the region.

Community members themselves will give personal accounts to listeners across Africa of how HIV/AIDS has affected their own lives. Broadcasting from Washington, we recognize that our reach is limited and thus we rely particularly on our affiliate stations in Africa to carry our broadcasts on local FM frequencies.

From a media perspective, they are on the frontlines in the battle to contain and prevent the spread of HIV/AIDS, and their efforts to educate their listeners truly inspire our admiration.

Some might ask, what business is it of Voice of America to become involved in the enormous, often frustrating task, of fighting AIDS in Africa? My answer is that this kind of health reporting is in the best public service tradition of American journalism. Just as VOA has had an effective role to play in the worldwide effort to eradicate polio, working alongside Rotary International, the World Health Organization and the U.S. Agency for International Development, it is now joining forces with others to confront HIV/AIDS. Even if this is not our first line of work, it is entirely appropriate for a news organization like VOA to form partnerships with other journalists and government agencies to leverage each other's contributions in the fight against HIV/AIDS, especially where opportunities exist to reach directly the ears of statesmen and policy-makers.

To conclude, by now few people doubt the importance to international security of the effort to deal with this disease. As we have reported on the Voice of America, there is a daunting worldwide recognition of the social, economic, political and even strategic threat posed by HIV/AIDS, once viewed as a medical issue of narrow importance. But let me make an obvious point. No amount of international support will result in a reduction in the rates of HIV infection across Africa if there is not outspoken indigenous African leadership on the issue and a broader view of the problem. Local media and international broadcasters like VOA have the potential

to create open spaces for a dialogue about how to prevent and contain HIV/AIDS, but without the bold support of respected national and community leaders in Africa in bringing this conversation closer to home, all efforts to halt the advance of this killer virus will be doomed to failure.

Thank you very much.

[The prepared statement of Mr. Ungar appears in the appendix.]

Mr. ROYCE. I thank you, Mr. Ungar.

Ms. Derryck, in the closing comments that Mr. Ungar was making, he was speaking to the fact that we need outspoken indigenous support from African leaders. You cited and I previously cited the situation in Uganda where a very aggressive and successful attack on AIDS through prevention seems to have prevailed, so much so that an AIDS rate that had been 30 percent, I think, in 1992 was 10 percent by 1998 in terms of infection rate. What are the key lessons that we can learn from Uganda? Is there something unique about Uganda that shaped their particular strategy?

Ms. DERRYCK. Thank you, Mr. Chairman. I certainly do agree with both you and Mr. Ungar that Uganda is a good example.

One of the keys is the leadership and the involvement not only of the President but of others in his Cabinet. We were talking the other day about infrastructures and whether the Ugandan infrastructure is any better than others in Africa, and there was a mixed opinion on that but there certainly are government resources that are used to maintain that infrastructure. So that is important. And another point would be that the government puts its own money into fighting the disease as opposed to relying simply on donors.

I think also the emphasis on education is important. Uganda makes a major investment in girls' education and that, of course, helps to prevent further infections as well.

And then lastly, the fact that they have been able to eliminate the stigma, because in so many countries when you declare your status then you become stigmatized and ostracized, and in Uganda that has not happened. In fact, there are so many NGOs, TASO and others, that work proactively to make sure that there is a caring support system available, it really does make a difference. So I think that all of those things help to contribute to their success.

Mr. ROYCE. I think that in Uganda, in the health centers, in the schools, pamphlets are readily available in terms of the deep stigmatization; you have situations where young ambassadors who go to different schools to talk to young people about this problem are made up half of children that are HIV-negative, half HIV-positive but without disclosing they share their stories. They do seem to do this in a way that conveys the information without creating in the society resistance to it, and it has had a remarkable effect on the decrease of the rate.

One of the questions that I have is what the U.S. Department of Defense is doing in terms of trying to work with African militaries to combat AIDS because we hear that that is a large part of the problem with HIV infection among the armed services. What exactly is the DOD doing in Africa and are any African militaries being utilized to combat AIDS in their specific societies?

Ms. DERRYCK. Mr. Chairman, we are very concerned about the role of the military because, for instance, in West Africa the ECOMOG (Economic Community of West African States Monitoring Group) troops from Nigeria and Sierra Leone and earlier in Liberia really are vulnerable to the disease and militaries are a vector of the disease.

We have special waivers now within USAID that will allow us to work with African militaries, and we have one program that is beginning in Nigeria. We have talked about the fact that testing would be a very good first step, and with the new cheaper VCT that I talked about, then that is one possibility, but AID will plan to work closely with DOD because it is a natural collaboration for a problem that really does span the entire continent.

Mr. ROYCE. Thank you. I wanted to ask Mr. Ungar a question, too, about which African governments are the greatest offenders in terms of censoring independent broadcasting. What I wanted to know was, are HIV and AIDS prevention messages ever blocked by governments or do they take a laissez-faire attitude and allow the broadcasts?

Mr. UNGAR. Well, Mr. Chairman, of course, we attempt not to be censored by any governments in Africa or anyplace else in the world, and the programs that we send in to Africa are going by shortwave, by medium wave, by FM through affiliates and now increasingly by television and the Internet as well.

I would say that there are some countries that are known to have suppressed local media coverage of HIV/AIDS. Zimbabwe would be one that I am sure you are familiar with. This has been rather taboo to be spoken of in Zimbabwe over recent periods. There is a remarkable parallel between the countries who have made progress and those in which there has been open discussion in the media.

For example, in Uganda, the discussion has been more open in the local media. In Senegal, that is certainly the case as well. Senegal has been a leader in West Africa. I think increasingly in Nigeria these issues are openly being discussed. The media have become freer with the return of civilian rule, as you know. We are particularly concerned that the VOA programs, the countries that would have the greatest impact in Africa, that these issues be treated. I would say that we have made a particular effort in all of our 11 languages that are going to Africa, but especially Hausa in Nigeria, Hausa and English in Nigeria, and then, of course, our Horn of Africa service, including our inherent broadcasts where our largest listenerships in Africa are in Nigeria and Ethiopia, and we have been treating these issues with particular care there.

Mr. ROYCE. I thank you very much. I want to go to my colleague, Barbara Lee of California, for her questions at this time. Let me say she has been a leader on this issue in the House of Representatives. Barbara.

Ms. LEE. Thank you, Mr. Chairman.

Let me thank you both for your presentations today. I want to, Ms. Derryck, state to you that I think given the minimal resources that you have that you are doing a fantastic job, at least in helping to begin to respond to this pandemic, and we are going to have to

figure out how to make sure that additional funding is available for the work that you do.

I was in Nigeria last year, it was actually on World AIDS Day, with Mr. Gejdenson and also very recently with President Clinton on his visit to Nigeria and to Tanzania. One of the issues that came up and that I read about and had discussions about had to do with the issue of blood transfusions and infections, the high rate of infections as a result of blood transfusions. I have talked to several officials over at USAID. I think I have talked briefly with yourself, Ms. Derryck, and I want to follow up and just find out if, in fact, we have the statistics with regard to the most infected countries, but especially with Nigeria. We heard maybe 10 percent of the 5 percent of the infections were as a result of blood transfusions. But even if it is 2 percent in a country such as Nigeria, that is an enormous amount of pain and suffering that doesn't have to exist, because we know how to deal with blood banks and blood transfusions.

So can you give us some feedback on that, what we know about that and what we are doing, if anything, to help African countries deal with that, deal with blood transfusion issues?

Ms. DERRYCK. Thank you, Congresswoman.

The whole issue of blood transfusions does come up frequently. I do not know an awful lot about the issue because I think it is something that we work with CDC on, and I will have to get back to you on the specifics of this. But let me just say a word about infrastructure, because we think about that a lot in terms of dealing with the pandemic. And the whole issue of blood transfusions and maintaining the purity of those transfusions I think really is compromised by imperfect infrastructures that we see all over the continent. It goes from the potable water to the lack of trained technicians, to the inability to carefully and systematically monitor blood transfusions. We see it basically throughout health care systems and other infrastructure, but certainly for health care systems in terms of HIV/AIDS.

But on the specifics, we will have to get back to you.

Ms. LEE. Thank you very much. Let me also just ask with regard to the programs in Uganda and Senegal, which I believe are the models, the examples for effective prevention and treatment, have they had the issue of blood transfusions to deal with? And then secondly, what is it about their approach and their strategies that have allowed them to be the model countries that have been able to get this under control?

Ms. DERRYCK. Let me just ask my colleague about Uganda and the blood transfusions.

My colleague says that the European Union has been involved over the long-term, and early on we were supporting some blood transfusions as well.

Ms. LEE. And what are the elements of both countries' strategies that could be adaptable in other countries that they really need to know that we maybe could support?

Ms. DERRYCK. First of all, it is that whole question of leadership and it is not only President Museveni but it is Mrs. Museveni as well, and when we start talking about stigma and women, that becomes an important component of what has happened in Uganda.

It is also the question of their investing their own resources in the fight of this. They have enlisted even leading entertainers in songs who have performed on this. They also have made a serious investment in nongovernmental organizations, and those NGOs spread the word and make sure that they have a very strong network that is supportive of people in the country.

Uganda has been fighting this for so long, but we have had more than a decade of experience with this. So, therefore, there is a culture now of accepting the disease and culture of confronting the issue, and so that helps as well.

Senegal has been very successful in maintaining a low prevalence because they too have had a major investment in research. Senegal has also worked very successfully with prostitutes and prostitutes who follow the military, and so they have been able to again publicize the fact of prevention and of safe sex. So that has been a major element of their success. But in both countries it is the investment of their own resources and in senior leadership and it is, as you said, breaking the silence, breaking the stigma of the disease.

Ms. LEE. In a perfect world, what dollar amount of money should we be looking at as a U.S. contribution?

Ms. DERRYCK. Oh, I am so glad that you asked me that. Thank you.

To halt the epidemic, we think that we need \$1.2 billion to \$2 billion. That is just for prevention per year in Africa. We need \$3 to \$4.9 billion for prevention and care. But those amounts exclude the infrastructure improvements that are necessary long-term.

Ms. LEE. What is our budget now?

Ms. DERRYCK. For Africa, it is \$114 million for 2000 and the request is \$139 million for 2001. So that is clearly not a very significant amount to begin to deal with this.

Ms. LEE. Why didn't you request \$1.3 billion?

Ms. DERRYCK. I would have to defer to the Administrator and to our own colleagues on that one.

Ms. LEE. Thank you.

Mr. ROYCE. Thank you, Congresswoman. We will now go to Congressman Greg Meeks of New York.

Mr. MEEKS. Thank you, Mr. Chairman. Let me just ask, just picking up right where my colleague Barbara Lee left off, some—you know, you talk about infrastructure. Some have argued that the underlying problem with HIV is the poverty that is in various countries or on the continent. To what degree is that true and do you think that we have to wipe out the poverty that is going on on the continent before we can really get to the HIV/AIDS problem?

Ms. DERRYCK. Thank you, Congressman, because this really is an issue for all of us who work in development. In the Africa Bureau, we say that our major goal, our major priority for all of our activities, is poverty alleviation. To get at poverty alleviation, you have to deal with education and you have to deal with increasing incomes; you have to deal with issues of nutrition, family planning and health.

There in that nexus of problems we see certainly an inability to respond to HIV/AIDS. When we begin to talk about anti-retroviral

drugs in Africa, I am reminded of the very graphic demonstration that my colleague gave. People said that we just want to see what these anti-retrovirals look like. So he went and got them out of a refrigerator, which most people do not have. He noted that you have to take them at a certain time, but people did not have clocks or watches, or a constant electricity even if they had the clock, and you need to have potable water. So just those three things demonstrated that maybe this is not the best solution to the problem, but it gets back to poverty and to the lack of infrastructure and sometimes back to just the basic adequate nutrition and diet. So they are all really interrelated, but I don't think that we can wait to solve the poverty problem, which is really long-term, before we have a massive attack on HIV/AIDS.

Mr. MEEKS. Well, given that, we know that some major manufacturers, major pharmaceutical manufacturers, have indicated they are going to reduce the costs or the charge for the retroviral drugs. Do you see any of the African nations being able to take advantage of that? Have they been taking advantage of it, and is that going to help, given still, even with the structural problems of not having refrigeration, electricity, et cetera?

Ms. DERRYCK. We welcome that kind of a contribution and we plan to—I guess all U.S. Government agencies plan to work as closely as we can with them. I am pretty sure that we will probably have to begin small and look at some possible demonstration programs, but they have to be in places where there is at least the potable water and the basic infrastructure that can accommodate those kinds of interventions.

We also have to make sure that the anti-retrovirals will be available long-term because the epidemic is long-term and so we are going to need the resources and the material over at least the next decade.

Mr. MEEKS. Well, I was recently in Ghana and they were talking about there, even with the reduced charges which, you know, they admit it was substantially cut but even with the smaller costs they could not afford it on a large-scale basis. Has there been anything that we have done or looked at with reference to maybe generic drugs and the distribution of the generic drugs that could further reduce the costs on the continent, the manufacturing of the drug somewhere on the continent?

Ms. DERRYCK. Again, I am not really aware of those kinds of efforts, and I would have to check with my colleagues and get back to you on that. I can tell you a little bit about it, that Nevirapine and the fact that it now is a very cheap drug that can be used for MTCT, and that it is certainly being used in Uganda and in some other countries.

Mr. MEEKS. I know we talked about the dollar amount. I don't know whether your agency or others—I mean, I happen to have seen when we were in Ghana on the ground there a company that was manufacturing and producing a generic brand of drug there, and I was wondering whether or not that is something that you or USAID have invested in or something that you would be interested in looking at?

Ms. DERRYCK. As far as I know—again, I will have to check this. As far as I know, we have not invested in this and it would be

something that I am sure that we would be certainly willing to discuss in conjunction with other agencies, especially if we get a plus-up for this because we need to look at multiple efforts to begin to deal with this problem.

Mr. MEEKS. Let me just have two more quick questions. We talked about Uganda and Senegal and their programs. We also have a program in Brazil and that program distributes anti-retrovirals in HIV programs. To what degree can we use Brazil as a model that we could emulate and copy on the continent of Africa?

Ms. DERRYCK. The Brazil program seems to have had some considerable success in prolonging lives, but I think we have to look at the prevalence rate there. Brazil has a health care system that is much more advanced than those that we see in African countries. Brazil has the eighth largest economy in the world, and while it has these real pockets of poverty it is, as you know, far more able in terms of infrastructure to support this kind of long-term investment. They also are a richer country than almost any of the African countries that we are talking about.

But I don't know. For Africa, because the prevalence rate is high and because the resources are so limited, we think that we really do need to focus on prevention and to put the resources that we have in a major way toward prevention as opposed to providing the anti-retrovirals as they have in Brazil.

Mr. MEEKS. Thank you, Mr. Chairman.

Mr. ROYCE. We will go to Congressman Tom Tancredo from Colorado.

Mr. TANCREDO. Thank you, Mr. Chairman. I have a couple of questions for actually both of you, I think, starting with Ms. Derryck. There are certain anomalies that present themselves when you look at the development of AIDS on the continent of Africa, one being the fact that although research has shown that better educated people are more likely to use condoms, but that especially in southern Africa the teaching and the nursing professions have been especially hard hit, essentially decimated. For either one of you, really, how would you explain this phenomenon or what I would call an anomaly?

Ms. DERRYCK. It is one of these really sad phenomena. I was talking to Sandy Thurman about this the other day, not about this but about the importance of education.

Mr. TANCREDO. I know you mentioned it in your testimony.

Ms. DERRYCK. It is that people should be more likely to change their behaviors in ways that would help them to avoid the disease. I was talking about in the case of Thailand, that that wasn't necessarily true in the general educated populations. We see teachers in southern Africa who are infected because—well, first of all because the infection rate is so much higher there. Second, that they are desirable, socially desirable, partners and, therefore, they may have more opportunities and they have unsafe sex. So that is one reason, and because the infection rates in the region are so high that makes it difficult, too.

We are losing teachers now at a rate faster than they can be replaced. This has, of course, devastating consequences for schools and for the ability to continue to even operate classrooms in some places.

There was an interesting piece in the New York Times about a month ago that talked about the experience of teachers in rural Cote d'Ivoire, the other side of the continent, but the fact that they are out there, they do not have access to condoms; they are desirable partners and there are more young women there, and that that is the nature of human beings and that is the consequence. So it is the lack of attention. It is the lack of access to condoms. It is the lack of attention to the messages, if they get out there, and it is basic ignorance.

We also know that 15- to 19-year-old girls in Kenya, 80 percent of them have no knowledge of ways to protect themselves from HIV/AIDS. So when you have students like that and teachers who should be more knowledgeable, then you can see that you are going to have a recipe for a very high prevalence rate.

Mr. TANCREDO. Well, exactly. It is such a challenging aspect of this because, of course, we want to rely upon education as the solution to not just this problem but so many, and yet it just doesn't seem to work. It doesn't seem to be the place in which—or the sort of cultural activity, societal activity, that we can rely upon in this particular area in order to accomplish the goal. It is a very disconcerting aspect of this, I might say.

I don't know, Mr. Ungar, do you have an observation that you would like to share?

Mr. UNGAR. Just briefly, Congressman, more so from my prior work at Africa than my duties now at Voice of America. I would only add two things to what Ms. Derryck said. One is that many teachers in Africa work away from their homes at schools, and do not have their families near them and therefore may have multiple partners. The other thing is that very often teachers are so poorly paid and may become involved in other things for the sake of earning more money.

I would just note that in the programs that we are about to do, and I can't remember if this was before or after you came in, but I was talking about this initiative we are making in southern Africa in English and Portuguese, and in the Cape Town area working with our affiliate Bush Radio. In Cape Town we are going to be having teen town meetings. We are going into the schools and that is part of the innovative aspect of this, is not just to be sort of broadcasting out there but to draw the schools in from the outset in these particular programs, and we are hoping that that will reach a greater number of teachers as well as students than our ordinary programs might have.

Mr. TANCREDO. Along the lines then of some of the issues with which we may be uniquely dealing, I should say, in Africa, although not entirely, but the practice of female circumcision, does it have an effect, do you think, on the spread of AIDS and ritual scarification? What about either or both of those two practices?

Ms. DERRYCK. Yes, but before I go to that I just want to say one more thing about education. Realizing that education is so central to dealing with this pandemic, we are having advisors work with ministries of education, again this is a multisectorial approach, but to make sure that ministries are aware of this problem certainly of teachers, but also of making sure that there is curricular mate-

rial that deals with HIV/AIDS so we can begin at that level to try to stem the pandemic as well.

So education is central. The teachers are one aspect of it, but the curricular response is another one.

In terms of female circumcision, there has been some work done on this and obviously if the knife or the implement that is used is not clean and disinfected then one runs the risk of becoming infected. But there has also been some interesting work, and it is not proved yet, that one of the reasons that there might be a lower infection rate in West Africa is because more young men, babies, are circumcised. So it is an interesting little twist there, but again as I said that has not been proved. But certainly female circumcision is an area that can increase the spread as opposed to in any way prevent or eliminate it.

Mr. TANCREDO. And ritual scarification?

Ms. DERRYCK. I don't know of any evidence on that. Again, I will have to check with my colleagues and get back on that.

Mr. TANCREDO. Thank you very much. Thank you, Mr. Chairman.

Mr. ROYCE. Thank you, Mr. Tancredo.

Before I go to Don Payne, let me say that this will probably be the last hearing of the Africa Subcommittee for this Congress and I want to express all of my appreciation to all of my colleagues, especially to the Ranking Member of this Subcommittee, Congressman Don Payne. I just want to say, Don, that I have very much enjoyed working with you over the last 2 years. I look forward to continuing efforts to see that America is as committed to Africa as it needs to be.

I also, Don, wanted to thank the staff here of the committee for their important work. Don, if you would like to question our witnesses now. Thank you.

Mr. PAYNE. Thank you very much, Mr. Chairman. First of all, I would ask unanimous consent to have my opening statement entered into the record.

Mr. ROYCE. Without objection.

Mr. PAYNE. Thank you. Secondly, along the same line, I certainly would like to, as I have done in the past and this is really not the mutual admiration society, he said it and I will say it now but I have done this before so it is not new, but I would certainly like to commend the gentleman from California, Mr. Royce, our Chairman, for the interest and dedication that he has taken on this responsibility.

I have been a Member of this Subcommittee now for 12 years and I have served with democratic chairpersons and republican chairpersons, and one thing that I must say is that out of all the committees I have served on this has been about the least partisan, but I also have to say that Mr. Royce has taken the seriousness of his responsibilities and he was at a disadvantage coming in because he did not know as much about Africa as he did about other parts of the world but I must say that I don't know of anyone who has learned more, has become more expert and has focused on the main problems of the continent of Africa. And I have said that when he has been present and I have said it when he hasn't been

present and I would like to thank you for the work that you have done on this committee.

Mr. ROYCE. Thank you. I appreciate it.

Mr. PAYNE. Let me ask a question or two in regard to, first of all, I think that the fact that we are discussing HIV/AIDS in Africa as relates to the continent is really a quantum leap forward because, you know, 4 years ago, 8 years ago, 6 years ago, 3 years ago we could not have the level of discussion that is necessary. As we know when things are kept in the closet, back in the change of the century mental health was something that was kept away from public discussion, it was something to be ashamed of, something people didn't want folks to know there was someone who may have a mental problem in their families, and until we started bringing mental health out into the open, discussing it here in the United States, did we finally start to come up with some kind of ways to remedy the situation. It is the same thing with HIV/AIDS in the United States. There was a lack of discussion for it and, of course, in particular in Africa there was even less. So I believe that one of the first steps is recognizing that there is a problem. Up until the present, there has been the denial that there is a problem, and so that is a victory, a very big victory, in my opinion.

So at least now in many areas we do know that there is a recognition of a problem and at different degrees though and levels we will see an attack on the situation.

Just 2 or 3 weeks ago I attended the Millennium Celebration in New York and at a luncheon that was sponsored by the Corporate Council on Africa, about 5 or 6 or 7 heads of state were present, and some prime ministers were present, Mr. Mugabe, President Festus from Botswana, Mozambique's president and on and on, and the whole theme of that luncheon was HIV/AIDS and they each took the mike and each talked about the problem in their country and each talked about what they were attempting to do. They varied from country to country, but as I indicated, 2 or 3 years ago you could not get that kind of discussion out in public, in the open, with heads of state saying we have a problem, we need help, this is what we are doing, it is not enough.

So for that reason, I do believe that with education, with awareness, we could at least have this situation really known and therefore start to deal with it. We know that there are a lot of obstacles to overcome.

Let me ask in relation to the legislation and let me, as I ask this question, commend Ms. Lee and Mr. Leach for the Global AIDS and Tuberculosis Relief Act but, Ms. Derryck, could you tell me how the act is coming along? What steps have been taken by the administration, unless you have already answered it, and the World Bank to set up the AIDS trust fund foreseen in H.R. 3519? And secondly, have donors come in? Have we donated? Have others donated? Has there been participation? And when do you expect the fund, if it hasn't started operating, to begin operating?

Ms. DERRYCK. Thank you, Congressman Payne. Before I begin, may I just join in your mutual admiration society because it has really been a pleasure. You know, we are energized by the concern that the both of you have shared and by your dedication and your

knowledge of the continent. So I think that it is a synergy that helps us all and we are grateful to you.

I would also like to underscore the fact that there really has been a sea change in attention among African leaders to this problem.

Last year at this time, at the ICASA (International Conference on AIDS and STDs in Africa) meeting in Lusaka, the prime minister of Mozambique stood and talked about the need for males and male leaders to change their minds, and that was revolutionary. We have seen within a year's period of time a total sea change among African leadership. So you are right.

In terms of the trust fund, we are very supportive of it, and we hope that there is going to be very good coordination because we see it within USAID as a real opportunity for synergy.

Our concern is that we don't want to see it come at the expense of our ongoing programs. I know I am like a broken record and say that all the time, but the pandemic is so huge that additive resources are welcome. It is going to take some time, I think, for the Bank and Treasury and us to get together for the financing. So we anticipate that it is likely to become operational over the course of the next 6 or 8 months.

I am not aware yet of other countries contributing to it, and I can just ask my colleagues if they are.

No, we do not know of any others, but I am sure that it is something that will be discussed in upcoming meetings when donors have a chance to get together.

Mr. PAYNE. Thank you. I would hope that the administration would push that in the future when those meetings come up.

Let me just conclude with this question. We have heard that the fact that poverty now is certainly put in almost as the number one problem and we have heard especially President Mbeki question whether HIV/AIDS is in itself what it is, but that tuberculosis and malaria and poverty in general are perhaps more of a problem than HIV/AIDS. It does make a lot of sense that poverty—indeed, when you have poverty and a lack of what you need, things are certainly going to be worse, but the fact that in spite of poverty—poverty was worse or as bad in Africa 20 years ago, 10 years ago, 5 years ago, as it is today, but over the past 20 or 25 years we have seen the life expectancy, in spite of this poverty, it has been there, it has been horrible, we have seen the life expectancy, in spite of this, tuberculosis was always there, malaria was always there, cholera always got into the water, et cetera, but we have seen the average age, life expectancy increase, actually even Botswana getting up to the high sixties and many countries in Africa gradually increasing each year. With the question of the HIV virus, is it everyone's opinion that this is just one of these seven or eight medical problems that we have in Africa or this HIV virus, which causes AIDS, is it a new serious kind of situation that really breaks down all of the previous gains that were made in spite of the poverty and these diseases that have always been around?

Ms. DERRYCK. I thank you, Congressman.

When we look back over time, you are absolutely right, that the gains in lower mortality and morbidity have been really very, very positive until now. When you look at the new charts that the U.S. Bureau of the Census has done and you see what is happening, the

inverted pyramid and these spikes in mortality in AIDS-affected countries, you do see that this is something that is new and unprecedented.

I just want to go back to what you said about tuberculosis and malaria because there is always this contention that malaria kills more people than HIV/AIDS. We know now that that is not so; that AIDS killed more people in 1999 and 2000 than malaria. So this is something that is new. In the United States, we have been able to deal with this because we have the infrastructure and we have the resources, and we put a lot of money into dealing with this, and we also have the media and other venues by which we can get people to change behaviors.

We don't see that in Africa. So as far as any of us know, it is something that is new. There is no cure. There is no vaccine. This is a different kettle of fish than we have seen previously, and it really does threaten to wipe out the development gains of the past 40 years.

Mr. PAYNE. Thank you very much.

Mr. Chairman, let me just also, as I complimented you, also thank you very much, Ms. Derryck, for that answer, thank colleagues on the other side of the aisle. As you know, Mr. Campbell will be leaving the House, he may be in the Senate, he may not be. That remains—none of us know where any of us are going to be on November 7, so we will leave that up to whatever happens, but I would certainly like to thank Mr. Campbell for the initiatives that he took and our many travels together, and also Mr. Amo Houghton, who has been a long-time Africa hand and was such an addition to the committee, and also on the other side, Mr. Tancredo, who took his first CODEL to southern Sudan. I told him that the only way you can take a CODEL is you have got to go to southern Sudan first and then you can go on the other ones.

Mr. TANCREDO. And I believed him.

Mr. PAYNE. He believed me. I don't know if there is a bigger odd couple on every other issue in the world, but sitting around the campfire going to our hut for the night, I don't think there is anyone that I could be on the same page with in the middle of Sudan than Tom Tancredo. So I would like to thank you again for traveling there with me. Thank you.

Mr. ROYCE. Thank you. I would also just like to thank Tom Sheehy, the staff director and Malik Chaka and the other members of the staff, including our interns that assist us here and do such a fine job. So we thank you all.

We want to thank our witnesses, our first panel, for making the trip down here today. We thank you so much.

We are now going to conclude our first panel and go to the second panel, so we will do that at this time.

Dr. Peter Lamptey is the Director of the Arlington, Virginia based Implementing AIDS Prevention and Care Project, or IMPACT project as it is known. He is also the Senior Vice-President of HIV/AIDS Programs with Family Health International, which is an NGO with more than 12 years of experience in HIV/AIDS programming in more than 50 countries, and prior to directing IMPACT Dr. Lamptey directed the AIDS Control and Prevention Project from 1991 to 1997, and the AIDS Technical Support Project

from 1987 to 1992. He was born in Ghana. Dr. Lamptey received his medical degree from the University of Ghana. He earned a Master's Degree in public health from UCLA and a doctorate in the same field from Harvard University.

Ms. Mary Crewe, with us through videoconferencing from South Africa, is the Director of the HIV Unit at the University of Pretoria. She has been involved with HIV/AIDS work for more than a decade. She helped to develop and manage the Johannesburg AIDS Center, which was the largest program in the region.

Ms. Crewe is the chairperson of the National Committee for School Based HIV/AIDS Education. She has published extensively in the field. She is also the author of the book *AIDS in South Africa: The Myth and Reality*. It is good to have you with us, Mary.

Also with us is Dr. Ashraf Grimwood, Director of the National Aids Convention of South Africa (NACOSA), with our U.S. AIDS Mission in South Africa. It is good to have you with us as well.

Mr. ROYCE. With that said, let's let Dr. Peter Lamptey open for 5 minutes. Again, Peter, if you could keep it brief and just a summation because we have your testimony here for the record, and then we will go to Mary Crewe's testimony.

**STATEMENT OF PETER LAMPTEY, SENIOR VICE PRESIDENT,
FAMILY HEALTH INTERNATIONAL**

Mr. LAMPTEY. Thank you, Mr. Chairman. I would like to especially thank you and this Subcommittee and all the Members of Congress, especially Congresswoman Barbara Lee, who have all been very supportive of the fight against the HIV/AIDS epidemic in developing countries.

As this Subcommittee requested, my testimony today will focus on the status of HIV/AIDS in Africa and the effective strategies for prevention and care.

During the last 14 years, Family Health International, with support from USAID, has been involved in HIV/AIDS programs in more than 60 developing countries. We have partnered with more than 800 nongovernmental organizations and community-based organizations of all types. Humbly, I would suggest to you that as a result of our experiences around the world with these NGO partners, we have an extremely broad, deep and unique perspective on the HIV/AIDS epidemic.

African countries south of the Sahara have the worst HIV epidemics in the world, as has been said by previous speakers. Adults and children are becoming infected with HIV at a higher rate than ever before. In sub-Saharan Africa with nearly 25 million people living with HIV and 4 million new infections every year, most of the progress achieved in the health and overall development is being reversed by this epidemic. In countries with high adult HIV prevalence, the chances of a young, uninfected adult encountering an infected sexual partner can be as high as 40 percent.

About 50 percent of HIV infections in Africa are in women, which also result in higher mother-to-child transmission, as has been described earlier.

Access to anti-retroviral therapy for the prevention of mother-to-child transmission is negligible in most of sub-Saharan Africa. The children affected by HIV/AIDS constitute one of the greatest trage-

dies of this epidemic. Over 12 million children in sub-Saharan Africa have lost one or both parents to AIDS.

In our HIV prevention and care programs, we have been guided by some key principles. These include the need to improve the capacity of implementing agencies in developing countries to implement successful HIV/AIDS programs. The second principle is to work closely with community-based organizations. This is extremely important. Indeed, a full 90 percent of the USAID-funded IMPACT activities are implemented by NGOs and CBOs. The third principle is involvement of the community, especially people with HIV and those affected by AIDS.

I will briefly mention some of the steps that we have taken for reducing the risk of sexual transmission and preventing mother-to-child transmission. The interventions that have had the most impact in reducing sexual transmission include community-based interventions, especially for youth and women; work-based interventions; school-based interventions, and intervention directed to the general population through mass media and condom social marketing. These approaches have been quite successful in a variety of countries, including Senegal, Uganda, Thailand and the Bahamas.

One of the most important interventions that bridges both prevention and care is voluntary HIV counseling and testing, which has already been alluded to. These programs have been successful in reducing high-risk sexual behavior, improving access to care, and serving as an entry point for the prevention of mother-to-child transmission.

In a program in Tanzania, VCT services led to a 37 percent reduction in high-risk behavior among those that were tested. The use of anti-retroviral therapy to prevent mother-to-child transmission is definitely one of the most important technological advances in the prevention of HIV, but the lack of resources continues to be a major obstacle to widespread access to this intervention.

However, the most neglected area of HIV/AIDS is access to medical care and support services. Most people living with HIV/AIDS do not have even adequate basic medical care. But, all this is affordable and feasible for people living with HIV/AIDS.

In conclusion, the HIV/AIDS epidemic continues its relentless spread, and the response is still woefully inadequate in most countries. More than 5 million people become infected every year; yet denial and discrimination still prevail.

However, our experiences overwhelmingly tell us that success in HIV prevention is achievable. We need to apply the lessons learned from successful prevention programs to other settings and expand the coverage of these programs.

We need to double our research and be forced to find a cure, or at least more effective and affordable therapies and a vaccine. We know what we need to do. We know that HIV prevention can work and care is urgently needed for those currently living with HIV/AIDS.

Mr. Chairman, I think you will agree that there is nothing worse than watching an innocent child or mother die a horrible death.

Let's work together to save the next generation of children in sub-Saharan Africa and other countries from HIV/AIDS.

Thank you for inviting me to testify today.

[The prepared statement of Dr. Lamptey appears in the appendix.]

Mr. ROYCE. Thank you, Dr. Lamptey, for your testimony before us today. We turn now to Pretoria and to Ms. Mary Crewe.

If you would give us a summation of your testimony, Mary, thank you.

**STATEMENT OF MARY CREWE, DIRECTOR OF HIV/AIDS UNIT,
UNIVERSITY OF PRETORIA**

Ms. CREWE. Thank you very much. Thank you for the invitation to be with you. I very much appreciate the opportunity to participate fully in your debate.

The crucial issues have been touched on in terms of AIDS in Africa, and that information has been transmitted to me. I have been looking more specifically at AIDS in South Africa. As you know, we have the fastest growing epidemic in the world. Approximately 22.4 percent of pregnant women are positive in South Africa. We know that we have up to 1,700 new infections a day, and I think we are at a crisis of unprecedented experience and magnitude.

I think there is a problem with the mike. Can you hear me?

Mr. ROYCE. No, you are fine, Mary Crewe. We can hear you without a problem.

Ms. CREWE. All right. What has happened in South Africa is that there has been a strong commitment to HIV/AIDS since 1994 and to some extent before that. We have had a general fiscal allocation for AIDS. We have had many instances to deal with the epidemic but there is a lack of a number of trained health care workers. We have various ranging programs. We have a number of strategic plans, and I think it is fair to say that in South Africa we have a very big HIV/AIDS population, but the paradox of this is that it has not translated into real behavior change. It has not translated into ending this incredible stigma and prejudice that was related to earlier, and simply it hasn't translated into mass community mobilization to get involved through an AIDS-free country.

As has been alluded to also, I think the role of the government recently has been somewhat controversial and the debates that have been conducted between the government, the media and various community groups have, I think, done two things. One thing is that they have set back the campaign around HIV/AIDS to some extent, but I think more interestingly they have raised the profile of HIV/AIDS to the level of emotional debate in a country which perhaps hasn't happened before, and there has been some awareness about the impact of AIDS on the country. I think it is crucial that, as our president has suggested, that we do deal with the issues around poverty but we have to look at poverty and unemployment.

South Africa still has what is classified as the fastest growing HIV/AIDS epidemic in the world. It is estimated that 22.4 percent of pregnant women are currently infected, with close to 1700 new infections per day. There have been many attempts to deal with the epidemic ranging from the life skills program in schools, to

training of health care workers and general AIDS-awareness campaigns.

This has created something of a paradox in that South Africa has a very HIV/AIDS-aware population but one in which very high levels of stigma, prejudice and denial exist and the awareness has not been translated into behavior change nor into great community mobilization to get involved and campaign for an AIDS-free country.

The role of the government has of late been controversial. The debates that have been conducted between the government, media and various community groups have done two things. They have raised the profile of HIV/AIDS in the public consciousness and have created some debate about the impact of HIV on South African development. However, the linking of AIDS to poverty as the causal agent has caused some confusion and a reluctance to admit that behavior change is crucial. As with previous campaigns that have been controversial, this has served in some ways to deflect the urgency, but for most people working in HIV and AIDS service organizations, research centers and hospitals and clinics, the belief is that it is business as usual and that the campaigns for prevention and care should not be affected and that the debates can give extra impetus to their work.

AIDS workers have always had to deal with high levels of doubt and denial, and this has allowed for a new take on how best AIDS education should be given.

These are areas of great concern. One is the inability of communities to cope with the demands of care and support. There are few policies which offer guidelines on crucial aspects of the transmission of HIV. We await decisions on the use of drugs in MTCT, as well as on the controlled use of anti-retrovirals. There also needs to be a careful decision on the provision of drugs in the absence of a real support infrastructure. Access to drugs is a highly charged issue, as is the question of compulsory licensing and parallel imports.

There is no formal policy on breastfeeding or on voluntary counseling and testing. There is no policy on the care for families and particularly orphans where it is quite clear that the so-called extended families will not be able to cope with the levels of care and support required. There is no policy on support for care givers and no real understanding what the impact of home based care will be. There seems to be even at a policy level an indecision and a lack of political will.

But there is much that is happening in communities through NGOs and CBOs. There are home based care programs, and there is the exciting potential of the development of a home based care kit that is likely to transform care in most communities. There are support services, food aid as well as community education and awareness and income generating projects. In the main these are uncoordinated and remain inadequate for the needs of the country, but the work that so many people is doing has not stopped because of the current debates.

The school-based program is being expanded and there are increasing interventions aimed at youth in both school and tertiary institutions as well as looking at ways to integrate youth not in school.

The picture is very bleak at the moment, but as a discussion we hosted on behalf of the AAI showed last week, it is by no means hopeless, there is still time to turn the epidemic around, there is still time to make an enormous impact in prevention and care and still time to rethink the policies and programs, especially with regards to orphans and families and communities in distress and most at risk.

But this requires new and creative vision, new ways of addressing the socioeconomic and political questions and a new understanding of what is possible in this epidemic and how best the society and country can hope to come through it.

Durban 2000 did energize the country and it's important to sustain that momentum. There is a great deal of concern and this needs to be channeled into actions that really will make a difference rather than looking at more of the same.

In conclusion, if I could just introduce the person who is on my right, who is, in fact, not Ken Yamashita, but is Dr. Ashraf Grimwood, who is the current chair of NACOSA (National AIDS Convention of South Africa), and physician of enormous experience in dealing with HIV/AIDS. Thank you.

[The prepared statement of Ms. Crewe appears in the appendix.]

Mr. ROYCE. Thank you, Mary. Thank you very much. Thank you for your thoughts there.

Maybe I could ask you a question about the faith communities that are active in South Africa, the Christian community, Muslim community, Hindu communities and others there. Do they play a role in HIV/AIDS prevention, the activities in that regard, in South Africa?

Ms. CREWE. I think that their role could be greater. They certainly do play a role, but I think that South Africa has a very difficult problem and that problem is the perception of the situation, or the reality of the situation, and the reality tends to get in the way of an effective campaign. So the prevention tends to ignore the reality, which is that we have a very high level of sexual activity among young people and a very high level of extramarital sexual activity, and I don't think that the faith organizations have really found a way to pass through that, but having said that, I think the faith-based organizations are very strong in the provision of care and support.

Mr. ROYCE. I see. Well, let me ask you another question that is perplexing, and that is on neighboring Botswana, which has, I believe, the highest rate of infection, 36 percent of adults; the worst hit country in Africa. Botswana is relatively prosperous and it has spent very little on HIV/AIDS programs. What has gone wrong in neighboring Botswana, in your view? Why has this situation developed there to such an extent?

Ms. CREWE. Well, what I found fascinating about Botswana is in general denial, and that is the explanation that South Africa has given for its epidemic, which is that you need to have high levels of poverty, migration and internal conflict to have a high epidemic. Botswana would seem to suggest that you don't have to have those requirements. I think that for Botswana, and I confess to not having studied the epidemic in Botswana terribly closely, but my sense of Botswana is that it is a very small country, and that they believe

that they were particularly not at risk of the epidemic and acted, as so many of our countries acted, too late. It is a very small country so the infection will spread very quickly, and I think it fits into the general denial that we have across South Africa. Uganda's response was exemplary. But I do believe that there is enormous denial, to a certain extent, of the epidemic.

So by the time your national infection rate has reached more than 12 percent, in effect no matter what you do you are facing a crisis.

Would you like to add to that?

Dr. GRIMWOOD. Well, I could say that the situation in Botswana has done a turn-a-round, and I think that there is immense government leadership. There is incredible focus on what needs to be done, and they have embarked upon several programs which would hopefully bring about positive impact in the next few years. So the feeling that I do get when I do travel and work in Botswana is that things are on the right track there.

Mr. ROYCE. Another question I wanted to ask, and maybe I should direct this at Dr. Lamptey, but it is clear that, as we have said, some African leaders have been very aggressive in promoting prevention. Others have not, and President Moi of Kenya faces a situation now where 14 percent of adults, I believe, are HIV-positive. He did not endorse the use of condoms as a preventive method until I think it was December 1999. Why was President Moi so reluctant to make this recognition? What holds back heads of state in terms of this issue of prevention, Dr. Lamptey?

Mr. LAMPTEY. I think there are several factors, not only in the case of President Moi but other African leaders, including President Mugabe. One of them is probably pressure of religious leaders not to agree to the use of condoms, and in the case of Zimbabwe, part of the reason was because they were afraid that it would increase promiscuity among adolescents. This is a belief despite of what has been consistently shown, in studies, that the availability of condoms does not actually increase sexual activity among adolescents.

In the case of Kenya also, I think, over the years has been the fear that some of these efforts will affect the tourist industry, which is an important economic base for Kenya. And so I think these are some of the major reasons. But for me there is no excuse for African leaders to sit on their hands and not act adequately enough to intervene in this epidemic.

Mr. ROYCE. I thank you, Dr. Lamptey.

We are now going to go to our Ranking Member, Mr. Don Payne from New Jersey.

Mr. PAYNE. Thank you very much. Thank you both, all of you, for your testimony. As I indicated earlier, I do believe that it is slow in coming, but I recall early discussions with President Museveni of Uganda 7 or 8 years ago where he was at this same stage that we find, say, President Mugabe and some of the other presidents that had been slower in coming to realization that there had to be education, that it is something that is here, that it is something we have to deal with; prevention can be by distribution of condoms, things of that nature, something that no head of state wanted to get up and discuss, and other cabinet level people, but

I did see the turnaround in Uganda after several conversations, as I indicated years ago, where there was absolutely objection to the things that are going on now in education and prevention.

I do have a lot of hope and faith in the new president, Festus Mogae, who has made the question of HIV/AIDS a number one issue. One of the pharmaceutical companies is there right now with a foundation, a Bill Gates Foundation. Bristol-Myers-Squibb is there with this project in Botswana where the realization has been made it is a sparsely populated country and at the rate, as you know, the population estimates are from 68 or 9 down to 39 or 40, is devastating and if this rate continues the country will have a negative population growth in 8 or 9 years.

So this is a very, very serious thing but I do think that perhaps some of the newer leadership, relatively younger leadership, like President Mogae, can take these questions on more forthrightly to deal with solutions to these problems.

On the educational situation, what type of educational programs, anyone could try to answer this, have you seen initiated and what problems do you see as relates to literacy and availability of communications techniques and materials?

Mr. LAMPTEY. Definitely lack of—

Ms. CREWE. Let me say—

Mr. LAMPTEY. Go ahead, Mary.

Ms. CREWE. Fine. After you.

Mr. LAMPTEY. Okay. Definitely lack of education. Ignorance plays an important role in the transmission of HIV. There are several programs that are geared toward increasing formal education of the general population, especially for young girls and young boys. But I believe that despite the poverty, despite the lack of formal education, HIV-prevention programs can provide education in prevention of HIV, and the success stories that we have seen in Thailand, Uganda, and other countries have been able to do this by simply providing relevant education to the populations that are at highest risk.

Definitely, formal education of girls and boys would certainly help in improving knowledge about HIV, and especially HIV-prevention, but I believe that specific prevention messages through mass media, radio, through local theatre, community-based interventions, all of these have played a major role in reducing the transmission of HIV.

Ms. CREWE. I would agree with that, but I would think that there is a real difficulty, which is that if what is going on in the society doesn't reinforce what is happening in the schools, or in the mass education campaigns, if the information is at this juncture without the understanding of the general society or the willingness of the society to accept the information, there tends to be a difficulty, and I think very often that people who have lived the reality, that overrides quite a lot of the education that they are given.

I think that we found in the school, certainly in the schools' programs, is that we made a mistake in some ways of concentrating the education on individual behavior where we come from a history in our country of many generations where people are not able to make individual choices around very crucial aspects of their lives. They couldn't choose where they lived. They couldn't choose where

they went to school. They couldn't choose who they would have sex with, and people's lives were so regimented that to now concentrate on individual behavior, without recognizing the historical past from which people have come and how communities operate and develop, I think is a setback, but I do believe that education has the potential to turn the epidemic around. But my interest is that in some ways it hasn't yet, and I think we—it means that we have to really assess what we are telling our people, the manner in which we are telling them, and treating them to a whole range of other messages that there are.

Mr. PAYNE. Thank you, Mr. Chairman.

Mr. ROYCE. Thank you. We will go to Mr. Tancredo from Colorado.

Mr. TANCREDO. Thank you, Mr. Chairman.

Mr. Lamprey, your testimony, in your testimony you specifically cite the VCT programs, voluntary HIV counseling and testing, as having been successful in reducing high risk sexual behavior, improving access to health care and serving as an entry point for the prevention of MTCT. Specifically, could you tell me exactly what aspect—why is that true? What happens in a VCT program that you believe provides this kind of change of behavior?

Mr. LAMPREY. I believe that the people who return to STD services are people who already have been informed of what is hazardous behavior or believe that they may possibly be infected. So you have these people who you are attracting who believe that they may be at risk of HIV.

Mr. TANCREDO. So you have sub-selected.

Mr. LAMPREY. And then having been tested, if they are HIV-positive, they realize that they need to change their behavior to protect not only their spouses and their casual partners, but also their families in the long run, and that's a message we give that even though you may be infected, it is still important to prevent your wife from getting infected and your subsequent children. For those who are uninfected, there is obviously relief, but at the same time, we emphasize the fact that you are lucky to have been unaffected at this time, but you need to change your behavior to make sure that you don't get infected in the future.

And I think basically, going back to the other question of education, most people have adequate knowledge about how the HIV is transmitted. I think in most countries 70 to 80 percent of the population are aware of the causes of HIV and how it is transmitted. What they need are the skills to change behavior, the access to condoms, how to negotiate for sex, especially women, and also all the things they need to do to empower them to be able to make that change, the switch from high-risk behavior to low-risk behavior. And, these are some of the things that we impart during our voluntary counseling sessions.

Mr. TANCREDO. It is encouraging on the one hand that something is working. It is discouraging that it is only for those people who have already placed themselves in the position of having access, I guess, to that kind of help, but so it begs the question of course how do we address—what do we do about the larger population that isn't necessarily interested in coming in for that kind of coun-

seling and the degree to which behaviors can be changed in any culture.

I mean, certainly I would love to know how anyone in your situation, anyone working with this problem in Africa, addresses the behavior or addresses the situation of high risk behaviors and trying to get people to look at abstinence, for instance, sexual abstinence, as a positive because we could then try that in this country, but we have many problems as a result of it, and I mentioned earlier that there were anomalies in Africa, but that is not one. High risk sexual activity among teenagers, and promiscuity and the kind of problems that that brings on, we certainly have our own dilemma. So I still wonder what can we do beyond that cohort that says, yeah, I am ready, I want to come in and find out what is wrong? How do we take that same lesson?

Mr. LAMPTEY. A couple of quick responses. One is that right now STD services are very limited. They are limited to stand-alone clinics that are in urban areas. They are not available in most parts of the country. So the first thing we need to do is to improve access.

The second, the reason why a lot of people don't go for it is because of stigma and discrimination. That is currently in most countries, Uganda has been cited as one of the countries where this may have diminished, but people are afraid to get tested because of the stigma that their spouses, their family, their friends and even workplace colleagues, the discrimination that will ensue.

And the last reason is cost. It costs anywhere from 10 to 20 dollars per person to be tested for HIV and counseled. Most countries still can't afford this and that is probably one of the major limitations to inadequate access to STD services.

Mr. TANCREDO. Any other comments?

Ms. CREWE. Well, we certainly agree with that. I think that the other point is that a lot of people to be tested in absence of any treatment means that people don't really see that it is interesting to know their status, if all they are going to be offered is advice that they should use contraceptives or condoms. That is fine, but for a lot of people they say if there is no treatment then why do I need to know my status, why should I actually deal with this in the absence of any support structures, any treatment, and most people in Africa know that there are drugs available that could significantly prolong their lives and would certainly have an enormous impact on the epidemic, and in the absence of those being available, I think there is a fair amount of cynicism of people saying that this is a kind of fatalism. There is nothing that can be offered to me if I'm tested, so why should I live with the anguish of knowing it.

So there's a sense of denial, and I agree with everything that was said before.

Mr. TANCREDO. Thank you. I think those observations are really cogent.

Mr. ROYCE. Thank you. We will go now to Congresswoman Lee.

Ms. LEE. Let me just thank both our panelists for their very profound testimonies and also just thank you for the work that you're doing. I know oftentimes being on the ground, especially with Mary and her colleague, can be, that can be overwhelming and oftentimes in the face of death and dying and pain and suffering con-

stantly that you are dealing with, and also to Dr. Lamptey, I know of your work throughout the world, and you are doing some very creative things. And I wanted to just ask you, following up on the previous question, could you explain the second generation surveillance and what this means and what level of resources are necessary to actually effectively implement second generation surveillance strategies?

And then let me just ask Mary, and you can think about this while Dr. Lamptey is responding: The orphan crisis is phenomenal, unbelievable, staggering, mind-boggling. I visited southern Africa with Sandy Thurman and a White House delegation year before last and I believe our findings and the report that we issued and the public awareness that we were able to present actually was somewhat useful in helping to begin to focus on this whole HIV-AIDS pandemic in sub-Saharan Africa, and I believe it was the orphan crisis that really initially captured the attention of many in our country.

I was talking with a minister of health from one of the countries in southern Africa, and she made a suggestion, and you mentioned creative approaches to solving or beginning to solve some of the support issues around the orphan crisis. One of those suggestions was that children whose parents are dying of AIDS may—we may want to look at how to help put these children in villages and begin to develop the infrastructure of the village so that they are transitioned into a stronger extended family unit, and the transition then would be easier and sustained once their parents passed away and then the villages would be a stronger village because of the economic development and the poverty reduction and issues that had been taking place.

This was a concept that I thought may make sense. I don't know if we have looked at any, and I would like to just ask you if you have seen any creative approaches in your work to the orphan crisis that really would help make—help these children live the kind of lives they deserve to live because I know the orphanages are under extreme duress because they don't have the resources to take care of 12 million children.

So first, Dr. Lamptey, let me just ask you now.

Mr. LAMPTEY. Thank you for your question. "First generation surveillance" took place in the early part of the epidemic and consisted of simply doing testing of selected population groups to give us an idea of what proportions of people were infected.

We moved beyond that to what we call the "second generation surveillance," which has a number of components. One, a systematic surveillance—serological surveillance of selected populations all over the country, including pregnant women, some high-risk groups like prostitutes, STD patients. That's the first component.

The second component is also collecting behavior data that gives a good indication of how people are behaving. The problem with serological surveillance is that it takes several years to change because of the long incubation period. However, behavior can change very quickly, and even in the countries that have been successful, the only way you can be truly sure that the changes in surveillance are due to the interventions is to actually document that behaviors have changed. Serological surveillance can change because of an in-

crease in deaths. It can change for a variety of other different reasons.

The third component is to also look at AIDS cases, STD cases, and the second generation combines all this data to be able to predict what is happening to the epidemic, the changes that are likely to occur, and how we need to change policy and change our interventions in order to be more successful.

Ms. LEE. Thank you. Can Mary, Mr. Chairman, answer the second question with regard to the orphans, please?

Ms. CREWE. Thank you. I tend to hold somewhat unconventional views maybe about orphans, but I think we really have to challenge the notion that the families and communities are simply going to be able on a large scale to rear the children. I think where they can we should encourage that, but I have a real concern, which is that if we accept the premise that poverty in many ways drives the epidemic, we really should not be putting policies into place that drive poverty, and so I think to impoverish households because we are expecting them to take in large numbers of children is cynical and unacceptable, and it also seriously jeopardizes the life chances of the children and those families who are not orphaned, and so we are double-jeopardizing children, I think.

The other is that I think in South Africa the whole history of the disruption of family life, the legacy of apartheid, has meant that lots of children are already not living with their natural parent and they have already skipped a generation to some extent.

I think part of the problem lies in a lack of looking beyond the status quo. We always tend to ask status quo questions and we get status quo answers, and we have never really looked at the way in which we integrate the department of housing, of transport, of welfare and health and education to come together to develop one kind of solution, and I really do think we have to look at not removing children from the community. Very often putting children in extended families means that they move huge distances from where they grew up. I would support the idea of some kind of very careful community-integrated institutional care and support, however, that looks—and I don't mean existing orphanages at all. But I really think we have to start challenging housing departments, architecture faculties, people to say we have to look after children for all kinds of ethical reasons, human rights reasons, security reasons and simply to secure our future, and if putting them into villages where you have key adults in certain positions, I think we have to experiment with that, and I am not meaning experimenting with children's lives at all, but failure to do that means that we are actually simply neglecting the children, and I think, assuming that there is an interest in southern Africa, that is actually neglecting the issue on the basis of what we believe is there.

So I am unaware of any children's villages operating in South Africa at the response to the orphan crisis, and I think one could do very, very fascinating work in looking at new ways of housing of children and I think we also have to look at new families. We have to reconceptualize how we define families and what families are.

Dr. GRIMWOOD. May I make a comment on that? The issues do precede, though, the situation when you have an orphan problem because children of positive families are at risk, and as their par-

ents become ill, they then are not able to be fed or cared for adequately. So they are therefore at greater risk of all these problems that have been mentioned earlier, and I think we tend to neglect this particular group.

But then just following on to an example of dealing with this issue, Botswana has brought a whole lot of organizations and ministries together to address their very large problem. They had 66,000 orphans, most of whom are not registered because of the stigma attached to registering orphans. And what they have done is present a nuclei whereby you have a house mother caring for six or seven children, and these children are assimilated quite rapidly into their community from whence they come once the social workers have been able to facilitate this process, and this is working quite well, but this is an initiative which is being done in many ministries, and I do think that there are approaches whereby we have to address this complex problem holistically. But I would like also to restate that we must not forget the children who are at risk and those who belong to positive families.

Mr. ROYCE. Thank you. I want to thank all our panelists and as we adjourn this hearing I would ask our two student interns to stand at this time, LaTrisha Swayzer of the University of Texas at Arlington and Alyssa Jorgenson from American University, and we thank you again for all the time you have put in both to these hearings and the research you have done for the Africa Subcommittee.

Thank you so much.

Mr. PAYNE. Mr. Chairman, would you yield for a minute?

Mr. ROYCE. I certainly will. Mr. Payne.

Mr. PAYNE. So that I do not hear it from my staff and the staff on this side, let me—you have so graciously introduced your staff, thanked them, even interns. Of course I have said nothing other than complain about why isn't this right here and the other. So let me also compliment my staff and the staff of the committee and all of the staff because they do work very closely together and they do a good job. Thank you.

Mr. ROYCE. Thank you, Mr. Payne, and with that we are going to adjourn this hearing. Thank you again to our panelists.

[Whereupon, at 4:25 p.m., the Subcommittee was adjourned.]

A P P E N D I X

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Subcommittee on Africa

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Statement of Chairman Ed Royce “HIV/AIDS in Africa: Steps to Prevention”

WASHINGTON, D.C. – The following is the opening statement from House Subcommittee on Africa Chairman Ed Royce (R-CA-39) on the AIDS crisis in Africa. Today’s hearing will be the last one for the year.

“Today the Africa subcommittee will look at the HIV/AIDS pandemic in Africa, particularly steps that can be taken to prevent its spread.

“The HIV/AIDS crisis has taken a devastating toll in Africa. An estimated 16 million Africans have died from HIV/AIDS. Two-thirds of the HIV-infected people worldwide — some 30 million — are in Sub-Saharan Africa. It is estimated that over the next ten years, AIDS will claim more lives than all of the wars of the 20th century.

“HIV/AIDS is damaging to Africa’s economic development. It absorbs sparse resources. It strikes down people in their prime of life. It destroys social cohesion. The AIDS epidemic is having an alarming impact on children in Africa. AIDS orphans run a greater risk of being malnourished, abused and denied an education. And because of women’s lack of economic and social power, Africa is the only region in the world in which women are infected with HIV at a rate higher than men. AIDS is ripping apart African families, while harming political stability and democratic development.

“As the Namibian secretary of health has written, prevention is the only weapon that will effectively halt the HIV/AIDS epidemic. There is no doubt, prevention efforts must overcome significant cultural, educational, and resource challenges, but this battle can be won.

“Progress demands a political commitment on the continent. President Yoweri Museveni of Uganda has raised AIDS in virtually every one of his speeches since 1986. With this commitment, including support for anti-AIDS village education projects that I have witnessed, Uganda has made impressive strides in reducing its HIV infection rate. Part of Uganda’s success can be attributed to the support of its relatively vibrant civil society, backed by private sector entrepreneurs. By contrast, President Robert Mugabe of Zimbabwe has barely uttered a word about AIDS in his 20 years in power. AIDS is devastating Zimbabwe.

“There is no question that the U.S. should be doing more to address the AIDS crisis in Africa. This means committing more resources.”

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Opening Statement
Congressman Donald M. Payne
Ranking Member, Subcommittee on Africa
Committee on International Relations
September 26, 2000

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Thank you very much for calling this hearing on the AIDS pandemic which has become a global national security threat spreading to all corners of the world but mostly devastating the African continent. Let me first thank, then congratulate my colleague Congresswoman Barbara-Lee (CA) for the vision, foresight, and tireless effort she put forth to fight this dreaded infectious disease. The passage of H.R. 3519, The World Bank AIDS Trustfund, signals the seriousness of this body's work.

The numbers have reached catastrophic proportions. You have heard them before. Up to one in four adults living in the inner city flat land of Johannesburg are HIV-positive -- double the statistic for the same area four years ago. In Botswana, the numbers are one in three.

The Clinton-Gore Administration has seen an unprecedented high-level engagement and partnership with the African leaders to respond to the AIDS epidemic. Our administration has begun a multi-faceted initiative to address the myriad of social, economic and health-related problems related to the global HIV-AIDS crisis. On July 19, 1999, Vice President Gore proposed \$100 million in additional spending for a global AIDS initiative to begin in FY2000, with a heavy focus on Africa.

And on January 10, 2000, the Vice President, who was chairing a session of the United Nations Security Council, announced a new U.S. initiative to combat AIDS overseas,

particularly in Africa.

I had the opportunity to travel with President Clinton to Nigeria, and Tanzania in August. This was our second trip to Africa. At that time, Clinton unveiled his proposal of providing \$8.75 million initiative for HIV-AIDS prevention and care, and a \$500,000 education program; this was in addition to the \$254 million already proposed earlier in the year. Similarly, Bristol-Myers announced a \$100 million initiative.

I am increasingly convinced, not only by the mounting statistical evidence, but also by the tragic stories of individual human beings, that HIV-AIDS is the most serious humanitarian crisis facing the world today and the greatest development challenge facing every nation in Africa. According to one intelligence report, "by 2010, [Asia, particularly India] the region could surpass Africa in the number of HIV infections."

I am anxious to hear from the witnesses some of whom I know traveled to the AIDS conference in Durban, South Africa and discussed issues such as mother-to-child transmissions. Once again, Mr. Chairman, thank you for calling this hearing.

**Testimony of Vivian Lowery Derryck
Assistant Administrator
Bureau for Africa
U.S. Agency for International Development**

before the

**Committee on International Relations
Subcommittee on Africa
United States House of Representatives**

Hearing on HIV/AIDS: Steps to Prevention

September 27, 2000

Introduction

Mr. Chairman, I want to thank you for holding this hearing on one of the gravest threats the world faces today. We are all too familiar with the grim reality of over 23 million people already infected and almost 16,000 persons becoming infected every day in sub-Saharan Africa. At least 10 persons get infected every minute. Half of all new infections in southern Africa, and 10 percent of new infections worldwide, occur in South Africa, now experiencing the fastest growing AIDS disaster. In 1999, AIDS was the largest killer, accounting for 2.2 million deaths in sub-Saharan African, more than double the 1 million deaths from malaria. By 2005, the daily death toll will reach 13,000 people with nearly 5 million AIDS deaths in that year alone. Although 70 percent of AIDS cases are

in Africa, the continent is home to only 10 percent of the world's population, reflecting the disproportionate impact of this epidemic. Preventing these infections and thereby protecting 70%-80% of the population not yet infected (even in high prevalence countries) should be the highest priority of both the affected countries and the international community. The proportion of the population not yet infected is as high as 95%-99% in a number of West African countries and in Madagascar. However, time is running out, and stronger actions are needed now.

Apart from the devastating impact of the epidemic on economic development, HIV/AIDS has played havoc with the lives of African families and has become one of the greatest human tragedies in recent history. Over 40 million children are estimated to become orphans by 2010 from all causes but 80% of them will lose one or both parents to HIV/AIDS. Mr. Chairman, this number amounts to 40 times the population of a country like Botswana. Reducing the vulnerability of these orphans to the disease to which their parents succumbed and reducing the stigma and social and economic problems are

keep them alive longer, providing medical care and support for affected children, supporting orphan's and vulnerable children's attendance in school, providing critical food aid to affected children and their families, and providing youth-oriented prevention messages to prevent future HIV transmission. These children, with proper care and training, can become responsible citizens and strong proponents of prevention messages.

USAID has led the fight against this epidemic since 1986. In the almost 15 years that

have passed, we and the international community have learned valuable lessons to prevent the spread of the epidemic and to care for those affected. The *Leadership and Investment in Fighting an Epidemic (LIFE)* initiative launched by the Administration, and supported by the Congress, last year reflected the package of interventions that have been shown to work to reduce HIV prevalence, as in Uganda, and to keep low rates low, as in Senegal. The initiative also provided necessary additional funds to begin scaling up these interventions. Our challenge is to apply the numerous prevention interventions that are currently available and that have proven their effectiveness.

Successful prevention programs incorporate a set of interventions: better availability of information, condoms and social marketing, mother-to-child transmission prevention, voluntary counseling and testing, access to support services for persons infected, and broad multisectoral approaches to the epidemic. In addition, the success of these interventions relies on efforts to reduce stigma, especially for women and youth; engage political, religious, and other leaders; and enhance training and technical assistance efforts, including Department of Defense efforts with African militaries.

USAID and other U.S. government agencies are supporting the expansion of these interventions. USAID is the largest bilateral donor for HIV/AIDS with a large presence of technical expertise in the field. Thanks to the commitment of the Administration and the Congress, USAID's response to the epidemic is constantly being enhanced. I must stress, however, that there is one significant constraint to stepping up our attack on HIV/AIDS. We need a strong commitment on the part of countries to effectively use the resources being pledged by the international community. We cannot, however,

continue to fund these programs in countries where leaders do not demonstrate

represent new and innovative strategies for prevention. USAID recognizes that provision of care services is also instrumental to encouraging prevention by creating entry points for prevention services and to provide affected persons with incentives to change behavior.

Use of Information and Education for Behavior Change

In the last decade, extraordinary progress has been made in disseminating information about HIV/AIDS in different countries. Despite these efforts, however, millions of people are still not well informed and thus are vulnerable. The vulnerability is especially high among girls due to lack of education, inadequate access to information from other sources, and generally lower economic and social status. For example, in many severely affected countries (e.g., Zimbabwe, Zambia and Cote d'Ivoire), twice as many boys as girls aged 15-19 know how to protect themselves.

Peer education has been effective among youth, as well as among certain vulnerable groups such as truck drivers and sex workers. USAID has funded, as one example, a new program called Africa Alive whereby music is used to reach youth with key HIV prevention messages. However, we have learned that information alone is not sufficient to change behavior. Issues such as stigma must be addressed. Giving people the tools to change behavior is also critical, as is the case with voluntary counseling and testing, which I will discuss later.

A study by UNAIDS indicated that people with more education were far more likely to protect themselves by using condoms for casual sex. An increase of even a few more years of schooling translated into a rise in condom use, especially among girls. USAID therefore has linked HIV prevention efforts with those to increase girls' access to education. The latter includes life-skill education as part of the multisectoral approaches to HIV/AIDS. USAID is leading donor efforts to mitigate the impact of HIV/AIDS on education systems in a number of countries such as South Africa, Zambia, Malawi and Ghana.

Delay in Sexual Debut

One of the main factors responsible for decline in prevalence in Uganda has been the delay in sexual debut by youth. Religious leaders were instrumental in inculcating ideas about sex within marriage and delays in the age of sexual debut. USAID has supported the involvement of religious leaders in programs such as those in Uganda and to promote safe sex. In Ethiopia, USAID support has helped religious leaders organize to tackle HIV/AIDS. USAID also is working with the White House Office of National HIV/AIDS Policy to plan a White House Religious Leaders Conference on HIV/AIDS in December 2000.

Social Marketing of Condoms

Without a vaccine, the only available means of protecting oneself from HIV is either changing behavior or use of condoms. In Africa, social marketing programs have been increasingly effective in educating about the use of condoms, and sales have soared

during the last few years. As a result, many countries are not able to meet the demand. On the whole, more men report using condoms than women and both sexes are more likely to use condoms for sex with casual partners. Studies have shown that young people are more likely than their elders to use condoms. This bodes well for the prevention of HIV/AIDS infections in the future.

USAID has been a major source of funding social marketing and condom distribution programs. Condom sales increased rapidly during the last three years in high and low prevalence countries. The former includes Uganda, Kenya, Zimbabwe and Tanzania and the latter includes Benin, Guinea, Ghana and Madagascar.

The availability of female condoms can add to the measures that women can undertake to protect themselves. The female condom is not meant to replace male condoms. Rather, its availability increases the options available to women to protect themselves. Unfortunately, the price of the female condom remains high and thus is not affordable by a large number of women. There are also issues concerning the design and ease of use of the device. USAID has provided funding to study the cost and design issues.

Voluntary Counseling and Testing

An Essential Part of Prevention

In the last few years, USAID support has been critical to expanding a promising and effective prevention strategy: voluntary counseling and testing (VCT). VCT is the process by which an individual undergoes counseling, enabling him or her to make an informed choice about being tested for HIV. If he or she chooses to be tested, there are provisions for post-test counseling and follow-up.

Let me stress that our efforts support this service only in a confidential manner. By expanding access to confidential VCT, we may also counteract the alarming trend growing in some areas and sectors, especially in certain workplaces, of mandatory or even secretive testing. This is a deplorable violation of the right of the people being tested, and is actually counterproductive to efforts to slow the spread of the disease.

There are compelling reasons for provision of VCT facilities in sub-Saharan Africa. UNAIDS estimates that 90 to 95 percent of Africans do not know their HIV status. As a basic human right, individuals should have access to information and services that will inform them of their status, whether they are sero-positive or sero-negative, if they wish to be so informed. As a public health measure it is important that people should know the risk of their behavior to themselves and to others. VCT enables people to plan their lives and is most effective for those who are about to make critical life decisions. Pregnant women who are aware of their sero-positive status can prevent transmission to their children, and parents can plan for the care of their children after they die. VCT has been shown to cause sexual behavior changes, at least in the short run. VCT also provides the necessary psychological support to those found to be sero-positive, even in the absence of antiretroviral drugs. VCT to screen for HIV/AIDS, when done in concert with efforts to diagnose other STDs, can help make people less susceptible to infection. Other sexually

transmitted diseases can make people many times more likely to contract HIV. One of the most important contributions of VCT programs is the normalization and destigmatization of HIV/AIDS. VCT contributes a collective sense that HIV infection is something that can happen to anyone, making it easier to engage in public discourse on prevention of HIV. This also creates the opportunity for people living with HIV/AIDS to organize into groups that can be pivotal in carrying forward messages about prevention and in the provision of care and support to others with HIV/AIDS. Finally, VCT provides an entry point to care.

Impact and Effectiveness of Voluntary Counseling and Testing

USAID supported the earliest efforts in providing VCT services in Uganda ten years ago, where national leadership and public demand created a supportive environment. As a result, the 1995 demographic and health survey indicated that over 67% of Ugandans were eager to know their HIV status. The USAID-supported AIDS Information Center became the major non-medical site to provide voluntary counseling and testing, which had served over 400,000 clients by the end of 1999. The number of clients and the demand has grown rapidly, and the facilities are being expanded nationally. The Uganda experience illustrates the importance of strong linkages between VCT services and support services for those testing positive and negative. Referrals to organizations, such as The AIDS Support Organization (TASO) in Uganda, provide clients with long-term social support, access to post-test clubs where both HIV-positive and negative persons meet and reinforce behavioral changing efforts, and care and support services for HIV-positive clients. TASO is now being replicated in other African countries. In Uganda, HIV prevalence among those seeking VCT declined from 23% to 15% among males and from 35% to 28% among females during 1993-97. Following Uganda's success, USAID helped introduce VCT in Kenya, Malawi, Zimbabwe, South Africa, Zambia and Tanzania. VCT has become one of the major responses to the epidemic.

In Zimbabwe, recent USAID efforts have led to large increases in demand. Using a social marketing approach, 31 sites were selected based on criteria such as availability of trained counselors, expected demand, and consultations with the stakeholders and communities. Both governments and non-governmental organizations run clinics.

VCT efforts in Kenya and Tanzania demonstrate that the proportion of individuals reporting unprotected intercourse with non-primary partners declined significantly for those receiving VCT compared to those receiving simply health information: reduction among men with VCT was 35% as compared to 13% with health information only. The corresponding figures for women were 39% and 17%, respectively. Condom use among all participants increased.

Future Prospects for VCT

The demand for VCT is growing in sub-Saharan Africa. Evidence in Zimbabwe and Malawi indicates that, once VCT services are made available, demand for the service is greater than had been anticipated. Additional efforts to increase the availability of mother-to-child transmission prevention rely heavily on the availability of VCT services

to identify vulnerable women. New technologies, such as rapid tests allowing same-day results, is making VCT easier for people by reducing the burden of having to travel back to a clinic to learn the results. VCT currently costs between \$12 to \$24 per person. However, personnel costs are the largest component of the total cost, as the test kits themselves cost \$1 to \$2.

Given the high value of VCT programs, countries and donors need to:

- **Expand the services:** VCT services should be offered as part of essential health care linked to other health services for awareness and treatment of sexually transmitted diseases. The structure of VCT services should be flexible to reflect an understanding of the needs of the communities they serve. Services should be linked with community organizations that can provide care and support resources.
- **Give special attention to vulnerable and high-risk groups:** VCT services should be developed to cater to the need of vulnerable groups such as women and orphans. Involvement of people living with HIV/AIDS is essential. Targeting high-risk populations, such as truckers and sex workers, can increase the cost-effectiveness of VCT.
- **Reduce the barriers to utilizing VCT and other services:** Stigma remains one of the most significant barriers to providing HIV/AIDS services. Prerequisites for the success of any intervention are policy dialogue and an enabling environment that allows frank discussion of the disease and its impact on individuals and society. We should encourage efforts to reduce the barriers to VCT in the public sector by governments at the national and local levels and by non-governmental organizations in communities and workplaces.
- **Recognize the limits of a single intervention:** Despite the demonstrated efficacy of VCT, there are concerns. The long-term impact of VCT is uncertain, first, because of the uncertainty of whether the safe sexual behavior will continue in the long run. Second, there are negative social and psychological consequences of poor counseling. The third issue relates to the difficulty of disclosure, particularly by women.

Prevention of Mother-to-Child Transmission

The problem of mother-to-child transmission (MTCT) is becoming increasingly urgent. MTCT is estimated to be the cause of about 10 percent of all new HIV infections and nearly 100 percent of all cases of pediatric HIV. About half-a-million babies become infected with HIV every year. Mother-to-child infections are likely to increase because of the growing epidemic among women. About 55 percent of all new infections in Africa occur among women. Of these, 70 percent are between the ages of 15 and 24 years. The ~~same~~ ~~infections~~ among women who are beginning their reproductive lives

infected mothers, it is estimated that two will be infected during pregnancy or delivery, one will be infected through breastfeeding, and seven will remain uninfected. Because multiple factors influence transmission of HIV from parent to child, USAID is supporting

a broad set of interventions to prevent MTCT.

Carefully implemented MTCT programs have the potential not only to save the lives of infants, but also to serve as a catalyst for improving and expanding HIV prevention and care services. MTCT programs highlight the need for expanded voluntary counseling and testing, for high-quality prevention programs for women who test negative for HIV, and for expanded programs to care for those infected with HIV.

USAID's approach to MTCT includes:

- Increase access to confidential, voluntary, HIV counseling and testing services. Services must be available and accessible to pregnant women and their partners so that families can make informed choices about their reproductive lives.
- Increase access to antiretroviral (ARV) therapy for HIV infected pregnant women; Short, affordable courses of ARV therapy have been shown to reduce HIV transmission by 20 to 50 percent;
- Train health workers to counsel women about infant feeding options, including safe breastfeeding and appropriate replacement feeding during the first two years of life;
- Train health workers in safe birthing practices that reduce the chance of HIV infection;
- Develop and implement minimum standards for antenatal care, essential drugs, nutritional supplements, and the correct choice and use of antiretroviral drugs for prevention of MTCT;
- Continue and expand primary prevention of HIV among women. This includes behavior change interventions; decision making and negotiation skills; early diagnosis and treatment of sexually transmitted infections; and increased condom use. Pregnant and lactating mothers who are HIV-negative will be targeted for enhanced primary prevention efforts;
- Develop community-based care services for HIV-positive mothers and link MTCT programs to these services. Women are reluctant to learn their HIV status when no services are available;
- Train health workers and other care givers in counseling techniques for HIV-negative as well as HIV-positive women and their partners about how to avoid risky behaviors, how to discuss their situation with their families, and, for those infected, how to live positively with the disease; and
- Assist in the management, logistical support and, if necessary, procurement of antiretroviral drugs for the purpose of reducing mother-to-child transmission.

This package of interventions holds promise of preventing up to 10 percent of new infections in Africa. However, it is one of the most complex interventions to deliver

undertake MTCT programs that have been designed with adequate community participation and sensitization. Health worker training will include emphasis on confidentiality, stigma, and health worker attitudes toward persons with HIV/AIDS.

Orphans and Vulnerable Children

As I mentioned earlier, the HIV/AIDS epidemic is producing orphans on a scale unrivaled in world history. It is difficult to overstate the trauma and hardship that the increase in AIDS-related morbidity and mortality has brought upon children. Denied the basic closeness of family life, children lack love, attention and affection, similar to children living in war-affected areas. They are pressed into service to care for ill and dying parents, removed from school to help with family or household work, or pressured into premature sexual activity to help pay for necessities their families can no longer afford, thereby escalating their own risk of infection. Often it is girls who suffer the most. Finally, these children frequently receive less health care attention.

Unfortunately the traditional responses to orphans -- developing institutions and orphanages -- is not appropriate for this crisis. Though in AIDS-affected areas there are increasing stresses to the capacity of extended families and communities to provide care, in most cases institutions are not an appropriate alternative. Institutions generally do not adequately meet key developmental needs such as consistency of care, especially for younger children. In addition, when children grow up without family and community connections, they are cut off from the support networks they will need as adults, as well as the opportunities to learn the skills and culture that children learn in families and in their communities.

Economically, institutional care is not financially feasible for large numbers of children. As African leaders have pointed out to us, this same level of resources can support many more children and families at the community level. In communities under economic stress, increasing the number of places available in institutions has often led to more children being pushed from family care to fill those places, where the material standards are seen as being higher than families can provide. This increases the scale of the problem and consumes resources that could do more if directed towards strengthening family and community capacities to care for vulnerable children. Institutional care can be helpful in those cases where there is no other immediate option, and it can serve as an interim solution while a fostering situation is arranged. However, children in this situation should be reintegrated into the community as soon as a reliable caregiver is identified.

Strategy for Intervention

When HIV/AIDS strikes, the first line of response comes from the children's families and communities. The extent to which the work of others -- governments, NGOs, religious institutions and donors -- is effective is a function of how well they support the efforts of children, families and communities. *Children on the Brink*, the seminal work supported by USAID, identifies five basic strategies of intervention that can help such efforts:

1. Strengthen the capacity of families to cope with their problems;
2. Mobilize and strengthen community-based responses;
3. Increase the capacity of children and young people to meet their own needs;
4. Ensure that governments protect the most vulnerable children and provide essential services; and
5. Create an enabling environment for affected children and families.

The illness or death of a parent often catapults a child into a harsh world. The first line of defense is to enable children to stay in school so they may acquire the skills to care for themselves. Interventions to help them remain in school must address the institutional, financial and other factors that cause them to fall out of the educational system.

Examples of effective interventions include: changing policies regarding fees or uniform requirements, providing at least one meal a day at school, providing schools with equipment, or renovation, in exchange for admitting vulnerable children and arranging apprenticeships with local artisans.

Conclusion

Mr. Chairman, one of the main lessons of Uganda is that a successful national effort must utilize all available tools and resources to achieve its goal. We cannot rely on one or two interventions to turn around the kind of epidemics we see raging in Africa. USAID is supporting comprehensive strategies that include the most innovative new strategies such as VCT and MTCT. USAID is committed to expanding and strengthening efforts in these areas. We will work with other donors to increase and coordinate support.

However, as I stated earlier, national commitment is essential for making donor efforts more effective. As part of these comprehensive strategies, USAID will address the special challenge of orphans. All parties -- donors, governmental and non-governmental organizations and communities -- must work together toward the overarching goal of creating an enabling environment for the affected families. Stigma should be reduced; vulnerabilities of children and families should also be reduced. This means changing public recognition of HIV/AIDS from "their problem" to "our problem" in this interdependent world.



Vivian Lowery Derryck

Assistant Administrator
Bureau for Africa
U.S. Agency for International Development

Vivian Lowery Derryck was sworn in as assistant administrator for Africa of the U.S. Agency for International Development (USAID) on July 24, 1998. USAID is the U.S. government agency that administers economic and humanitarian assistance worldwide.

Before joining the agency, Ms. Derryck was a senior vice president and director of public policy at the Academy for Educational Development, a U.S. private voluntary organization (PVO) that concentrates on human resource development and capacity-building in the United States and more than 70 countries abroad.

Ms. Derryck recently concluded her work as the senior adviser of the Africa Leadership Forum, the premiere African non-governmental organization concerned with strengthening senior African leadership and promoting democratic development on the continent.

From 1989 to 1996, Ms. Derryck served as president of the African-American Institute, a multi-ethnic, multi-racial PVO focused on African economic, political and social development. During her tenure, its budget doubled from \$17 million to \$34 million per year.

Ms. Derryck has worked in more than 25 countries in Africa, Asia, Latin America and the Caribbean.

Her first job after graduate school at Columbia University was with the African-American Institute. Subsequently, she taught at New York City Technical College and developed African curricular materials at the Education Development Center in Boston, before leaving for Liberia in 1973. She spent four years teaching at the University of Liberia and working with the Ministry of Education to Liberianize the social studies curriculum.

Ms. Derryck returned to the United States in 1977, with consultancies at USAID and the U.S.

House of Representatives. She served as a deputy assistant secretary of state in the Carter and Reagan administrations, holding portfolios under four secretaries of state.

Following her government service, Ms. Derryck became the executive vice president of the National Council of Negro Women and director of its International Division, running projects in Swaziland, Togo, Senegal and Mauritania.

A specialist in political development and governance, from 1984 to 1988 Ms. Derryck was vice president for programs of the National Democratic Institute for International Affairs, a Washington-based political development institute. In 1988, she became the executive director of the Washington International Center and a vice president of Meridian House International, before assuming the presidency of the African-American Institute in 1989.

Ms. Derryck is a member of numerous boards and committees and has received many honors and awards, including the Martin Luther King National Service Award (1998); the National Council of Negro Women International Women's Day Award (1998); Guggenheim Museum Humanitarian Award (1996); Honorary Doctorate, Chatham College (1995); UNICEF African Partnership Award (1995) and Woman of the Year, Sierra Leone (1991).

Ms. Derryck has a master's degree in international affairs and a certificate of the Regional Institute of African Studies from Columbia University School of International Affairs and a bachelor's degree from Chatham College. She also completed the Executive Management Leadership Training Program at the Federal Executive Institute.

TABLE 1. - *Continued*

[illegible]

the virus.

But media in Africa are not always operating on a level playing field, particularly when it comes to coverage of HIV/AIDS. They often find themselves subject to censorship by governments still coming to terms with the scope of the virus and the

catastrophic consequences it portends for their countries. In the absence of unambiguous, authoritative statements by some African leaders about the importance of preventing the spread of HIV/AIDS and tolerating and supporting those who have the disease, popular misperceptions and cultural taboos about transmission and treatment have been allowed to flourish – thus making the media's role much more difficult to accomplish. And that is why outsiders must help.

While we may be disappointed by the paucity of discussion and understanding in African societies of HIV/AIDS, it may be instructive to reflect for a moment on the gradual shift in public understanding of HIV/AIDS here in the United States, due largely to the way American media have covered this emerging story over the course of the past two decades. Let's turn back the clock for a moment to the early 1980s and recall how the mainstream media in the United States handled the story. A July 1996 report in the *Columbia Journalism Review*, entitled "Covering the Epidemic – AIDS in the News Media, 1985-1996," provides insight into how the media's coverage of HIV/AIDS evolved in that period. At one point, AIDS was actually referred to as "GRIDS" (Gay-Related Immuno-Deficiency Syndrome), and was believed to be uniquely a gay men's disease. It wasn't until August 8, 1982, that the *New York Times* informed its readers about a growing health crisis in the homosexual community that was baffling medical science, and actually termed the disease "AIDS" for the first time. Later that year, the public picture became more complicated when the *Washington Post* reported on the death of an infant who had received a blood transfusion from an HIV/AIDS – infected donor. Still, a June 1983 *Newsweek* poll found that ignorance about the virus was widespread in the United States, with 40 percent of those surveyed either believing that AIDS could be acquired through casual contact or unsure about whether it could be transmitted this way. Since that time, the mainstream media have shifted from treating HIV/AIDS as purely a health issue to taking up its cultural, economic, and geopolitical dimensions, and they have attached human faces to the virus to demonstrate its social impact. Inasmuch as this shift in public understanding of HIV/AIDS occurred over nearly two decades in the United States, it is hardly surprising that open discussion of the nature and causes of HIV/AIDS remains a stumbling block for media organizations elsewhere in the world, including Africa, where many are still under state control.

While we in the media have come a long way toward understanding what HIV/AIDS is and is not, our enlightenment will prove inconsequential if we fail to reach people who urgently need such information in meaningful ways. In Africa, radio is king, and it is often the most effective means of reaching people and correcting distortions of

an international one with a global presence like the Voice of America, or a small local community outlet in Mozambique or Zambia, it has to develop new, innovative programs targeted to its particular audience if it is going to be relevant to people and affect their behavior. This must be done even at the risk of intruding, violating the old code of silence, or offending sensibilities.

I would like to describe for you a few ways that the Voice of America and some of its affiliate stations in Africa are working on this problem. VOA broadcasts into African homes in eleven languages everyday. Over the past fifteen years, we have made stories about HIV/AIDS a broadcasting priority, and our features on the topic have tried to help some 36 million listeners in Africa make informed choices about dealing with the disease. We have featured discussions with experts from the National Institutes of Health and the World Health Organization. A global teleconference of HIV/AIDS specialists, held at VOA in September 1997, was made available by special broadcast to rural African doctors. VOA has covered each of the past thirteen international AIDS conferences, and we have reported on the efforts of non-governmental organizations (NGOs) in Africa to raise levels of awareness and tolerance toward people afflicted with the virus.

VOA's programs on HIV/AIDS are not limited by any means to shortwave radio, or even to medium-wave or FM. The Internet and television amplify the impact and reach of these broadcasts. Already VOA streams nearly 70 hours of live or on-demand programs to Africa on the Internet each week, and we are poised to take further advantage of this technology as it develops on the continent. In urban areas throughout Africa, where television rivals radio in popularity, VOA affiliate stations broadcast *Africa Journal*, a popular weekly call-in television program. *Africa Journal* has tackled HIV/AIDS-related issues from many angles, and has featured the opinions of policy makers, activists, and average citizens in Africa ever since going on the air nine years ago. For many African viewers, it has created the kind of space for open dialogue about HIV/AIDS that may be difficult to find in their own communities. A new VOA weekly radio/television simulcast, called *Straight Talk Africa*, has just been launched and will also treat HIV/AIDS in upcoming segments. For those programs and others, including *This Week*, an English-language TV news magazine shown by several African networks and individual stations, VOA video journalists, equipped with hand-held digital cameras, have learned to enhance HIV/AIDS-related stories with powerful images.

The effectiveness of information is often difficult to measure, but there are some telling signs that we have had an impact. Earlier this year, the director of Rwanda's National Anti-AIDS Program cited VOA's Central African Service for its help in raising awareness among his countrymen about the impact of HIV/AIDS on their society. He noted that the number of Rwandans who now admit to carrying the disease has increased. Similarly, in Burundi, HIV/AIDS patients have made public statements that being HIV-positive is neither a sin nor a source of shame.

Every broadcaster's worst nightmare is to produce a program that he or she is proud of but no one is listening to. HIV/AIDS is one of those topics that, if discussed in a

manner that sounds preachy or condescending, could result in many a radio being clicked off by otherwise receptive listeners. Thus, understanding one's audience is essential to achieving results. A soccer tournament in Africa, with thousands of captive listeners clinging to their radios to hear the play-by-play, proved to be an excellent opportunity to talk to men about HIV/AIDS. In a fine example of developing messages geared to an especially vulnerable segment of the population – young men in their teens and early twenties -- VOA joined forces with the Confederation of East and Central African Football Associations and the Johns Hopkins University Center for Communication Programs to develop a series of HIV/AIDS-related messages that were broadcast during soccer games. Soccer players themselves – genuine heroes in Africa – recorded public service announcements promoting the use of condoms and other preventive measures. These broadcasts went over so well that they earned VOA an award from the Confederation of East and Central African Football Associations, and several African sports reporters teamed up to form the Association of Sports Journalists for Health / East and Central Africa.

Funded in part by a grant from Cable Positive, a foundation associated with the cable television industry, VOA is about to embark on its most ambitious and innovative HIV/AIDS programming yet, a special project in English and Portuguese for Southern Africa. Working with two of our affiliate stations -- Bush Radio in Cape Town, South Africa, and Radio Pax in Beira, Mozambique -- we will produce HIV/AIDS awareness concerts commemorating World AIDS Day in December. At the concerts, through songs and role-plays, musicians and drama groups will address the need to end the silence and stigmatization associated with HIV/AIDS. Leading up to the concerts will be a series of teen-town meetings with youth in Cape Town area high schools, and a community-wide town hall meeting in Beira, about HIV/AIDS-related issues.

At the same time, VOA will create a radio documentary mini-series in English and Portuguese, identifying certain communities in Southern Africa, and even particular individuals, to follow over the next two years in order to understand better the impact of HIV/AIDS in the region. During this two-year period, linking the recently concluded World AIDS Conference in Durban with the next one in Barcelona in 2002, VOA will assess whether any messages emanating from the Durban conference have reached and affected these communities. Stories will look at such issues as whether treatment and drugs are more readily available; whether there has been a change in infection rates; whether personal behavior has evolved; and whether people are more willing to talk openly about the disease. Community members themselves will tell these stories through their own eyes and with their own voices. The listening audience will hear from many of the same "cast" of individuals on a recurring basis.

No matter how tear-jerking an AIDS-orphan's account of his or her plight is -- or how disgusted it makes us to learn that, in some African and other developing societies, people believe they can be cured of HIV by having sex with a young virgin -- an audio or visual account of these stories will only go as far as one's own eyes and ears and personal experiences will allow. Heard or read in isolation, such a story about HIV/AIDS may

have a limited impact on any individual. If it is heard or read as part of a group discussion, however, the impact on one's behavior may be greater. Broadcasting from Washington, D.C., we realize that our reach is limited, and thus we rely on our affiliate stations in Africa to carry our broadcasts on local FM frequencies. From a media perspective, they are on the front lines in the battle to contain and prevent the spread of HIV/AIDS, and their efforts to educate their listeners truly inspire admiration.

Take Bush Radio in Cape Town, for example. Bush Radio is an all-volunteer community station that has developed some cutting-edge programs targeting high school youth in some of the roughest areas of that city. Already they produce a weekly "HIV/HOP" program hosted by teens, weaving hip-hop music into a call-in talk-show format. They have won over inherently suspicious principals and teachers, and are now allowed to visit the schools regularly to hold information sessions with students about HIV/AIDS prevention and tolerance. Leading up to World AIDS Day and our Cape Town concert on December 1, Bush Radio will broadcast live the four teen-town hall meetings it is holding, and later VOA will broadcast portions of them to all of Africa. Bush Radio will also produce its own HIV/AIDS awareness public service announcements that VOA will in turn use on its broadcasts throughout anglophone Africa.

Radio Pax, in Beira, the second largest city in Mozambique, is another example. Despite the devastation of last year's floods, Radio Pax -- with a staff of fewer than ten people and a studio that is little more than a van with an antenna and a phone line -- remains the city's most popular radio station. Each week, it broadcasts a thirty-minute program on HIV/AIDS-related issues, featuring health experts and government and community leaders. And as part of its World AIDS Day activities this year, Radio Pax will host a first-ever community-wide town hall meeting on HIV/AIDS. In countries where discussion, understanding, and acceptance of taboo subjects occur incrementally, these activities represent meaningful steps forward.

Some might ask: what business is it of Voice of America to become involved in the enormous, often frustrating, task of fighting AIDS in Africa? My answer is that this kind of health reporting is in the best public-service tradition of American journalism. Just as VOA has had an effective role to play in the worldwide effort to eradicate polio -- working alongside Rotary International, the World Health Organization, and the U.S. Agency for International Development -- it is now joining forces with others to confront HIV/AIDS. Even if this is not our first line of work, it is entirely appropriate for a news organization like VOA to form partnerships with other journalists and government

cooperation between two now-separate agencies in the fight against HIV/AIDS.

By now, few people doubt the importance to international security of the effort to deal with this disease. The United Nations has joined the U.S. government in attempting to draw attention to the urgency of this challenge, in Africa as elsewhere. As we have reported on the Voice of America, there is a dawning worldwide recognition of the social, economic, political, and even strategic threat posed by HIV/AIDS, once viewed as a medical issue of narrow importance. But in closing, let me make an obvious point: No amount of international financial, political, or technical support will result in a reduction in the rates of HIV infection across Africa if there is not outspoken indigenous African leadership on the issue and a broader view of the problem. Local media and international broadcasters like VOA have the potential to create open spaces for a dialogue about how to prevent and contain HIV/AIDS; but without the bold support of respected national and community leaders in Africa in bringing this conversation closer to home, all efforts to halt the advance of this killer virus will be doomed to failure.

Sanford J. Ungar, Director of the Voice of America since June 1999, has been a journalist in Washington for more than thirty years. He is a past managing editor of *Foreign Policy* magazine and has written and spoken widely on international issues for a general audience. He is a former host of "All Things Considered" on National Public Radio and author of the best-selling book, *Africa: The People and Politics of an Emerging Continent*, first published in the mid-1980s.

SANFORD J. UNGAR

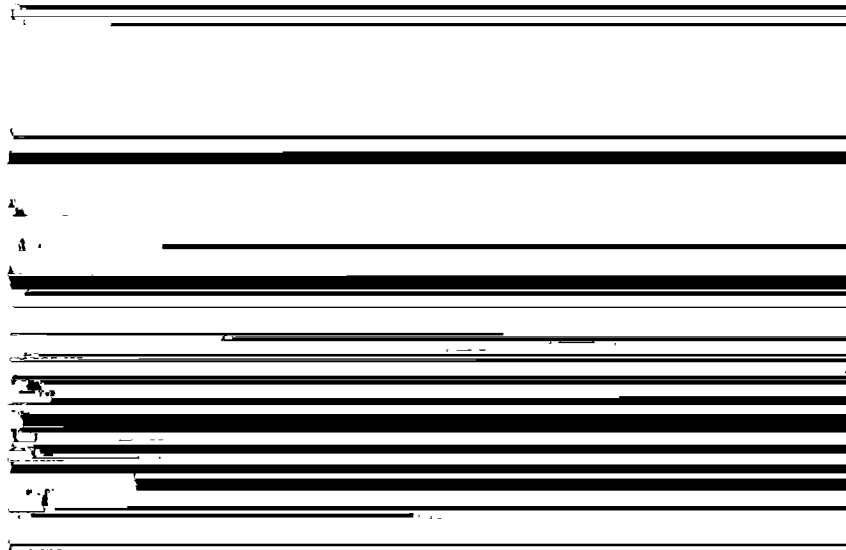
Sanford J. Ungar became the 24th director of the Voice of America in June 1999. In that capacity, he oversees more than 900 hours a week of VOA broadcasts in English and 52 other languages to some 91 million people around the world.

Prior to his assuming his position at VOA, he was dean of the School of Communication at American University in Washington, D.C., for thirteen years.

He is the author, most recently, of *Fresh Blood: The New American Immigrants*, which was published by Simon and Schuster in October 1995. It is the result of more than four years of research among immigrant groups around the United States. The paperback edition of *Fresh Blood*, with revisions and a new afterword, was published by the University of Illinois Press in 1998.

Mr. Ungar's career in print and broadcast journalism spans more than a quarter of a century. Between 1980 and 1983, he was the host of several programs on National Public Radio, including the award-winning "All Things Considered." He has also often appeared on public, commercial, and cable television, frequently as a commentator or as the moderator of debates.

He is the author of many magazine and newspaper articles on topics of political and international



DR. PETER R. LAMPTEY, MD., Dr. P.H.
Senior Vice President, AIDS Programs
Family Health International

Testimony
HIV/AIDS Steps to Prevention
U.S. House of Representatives
House Committee on International Relations
Subcommittee on Africa

September 27, 2000

Introduction

Thank you, Mr. Chairman.

I would especially like to thank you... this Subcommittee... and all the members of Congress who have been very supportive of the fight against the HIV/AIDS epidemic in developing countries.

As this Subcommittee requested, my testimony today will focus on the status of HIV/AIDS in Africa and effective strategies for prevention and care.

Many of you are already familiar with Family Health International, or FHI. For those of you who may not be familiar with FHI, our mission is to provide the highest quality services, education and research in family health, family planning and reproductive tract infections, including HIV/AIDS and other infectious diseases, such as tuberculosis.

During the last 13 years, Family Health International has been involved in managing HIV/AIDS programs more than 60 countries with a particular emphasis on nations in sub-Saharan Africa, Asia, Latin America, and the Caribbean. We have partnered with more than 800 NGOs and CBOs of all types. These groups range from organizations that are taking on HIV/AIDS prevention and care, to local community development and health NGOs, women's associations, trade unions, Fortune 500 companies, local churches, and youth groups.

FHI is now ending our third year of working with USAID to carry out the five- year IMPACT Project. IMPACT is the acronym for the "Implementing AIDS Prevention and Care Project." We have 5 outstanding partners involved in the IMPACT project. They are the Institute for Tropical Medicine in Antwerp, Belgium; Management Sciences for Health in Boston; Population Services International here in Washington; the Program for Appropriate Technology in Health, based in Seattle; and, the University of North Carolina in Chapel Hill. Humbly, I would suggest to you that, as a result of our experiences around the world with these NGO partners, we have an extremely broad, deep, and unique perspective on the HIV/AIDS

pandemic.

Having been with FHI myself since 1981, I am pleased to say that many of the “best practice” models for global HIV/AIDS intervention have emerged from FHI’s work funded by USAID.

Status of HIV/AIDS in Africa

African countries south of the Sahara have the worst HIV/AIDS epidemics in the world. Adults and children are becoming infected with HIV at a rate higher than ever before.

In sub-Saharan Africa, with nearly 25 million people living with HIV and 4 million new infections every year, most of the progress achieved in health and overall development is being reversed by the AIDS epidemic. In countries with high adult HIV prevalence, the chances of a young, uninfected adult encountering an infected sexual partner can be as high as 40 percent.

With more than 2 million deaths a year and the highest AIDS mortality in the world, access to basic AIDS care and support is extremely poor in most SSA countries. TB which costs approximately \$7.00 to prevent and about \$15.00 to treat, kills 30-40 percent of AIDS patients.

About 55 percent of HIV infections in Africa are in women, which result in high mother-to-child-transmission, which is known as MTCT. Access to anti-retroviral therapy (ART) for the prevention of MTCT is negligible in most of sub-Saharan Africa.

The children affected by HIV/AIDS constitute one of the greatest tragedies of this epidemic. Over 12 million children in sub-Saharan Africa have lost one or both parents to AIDS.

Approaches to Prevention and Care

In our HIV/AIDS prevention and care programs, we have been guided by some key principles. These principles have been essential for successful implementation of interventions.

The first principle is to ensure that we improve the capacity of implementing agencies in developing countries to design, implement, manage and evaluate successful HIV/AIDS programs. These include the private sector, the public sector and non-governmental organizations.

The second principle is to work closely with community-based organizations, or CBOs. This is extremely important. Indeed, a full 90 percent of IMPACT activities are implemented by NGOs and community-based organizations (CBOs) in the 40 countries where the program has a presence.

The third principle is the involvement and participation of people with HIV/AIDS and communities infected and affected by AIDS. Local individuals and communities as a whole need to be involved in both prevention and care programming.

Strategies

There are three key strategies for the prevention of HIV – number one: preventing the transmission of HIV through blood transfusions and intravenous drug use... number two: reducing sexual risk of infection... and number three: preventing mother-to-child-transmission, or MTCT. I will focus specifically on reducing the risk of sexual transmission and preventing MTCT.

The interventions that have the most impact in reducing sexual risk are the following: community-based interventions especially for youth, and women, work-based interventions, school-based interventions and general population-based interventions through mass media and condom social marketing programs.

These interventions are focused primarily on abstinence, reduction in the number of sexual partners, the promotion and use of condoms, and the treatment of sexually transmitted diseases (STDs).

These approaches have been quite successful in many small-scale programs both in Africa and elsewhere. They have also been successful at the national level in Senegal, Uganda, Thailand, and the Bahamas. For example, within a five-year period, condom use in Uganda increased about 4 fold among men and about 7 fold among women.

One of the most important interventions that bridges both prevention and care is voluntary HIV counseling and testing, known as VCT. It is estimated that less than 10 percent of the 25 million people infected in Africa are aware that they are infected. VCT programs have been successful in reducing high-risk sexual behavior, improving access to care and serving as entry point for the prevention of MTCT. In Tanzania, VCT services led to a 37 percent reduction in high-risk behavior. However, the coverage of VCT programs is limited to a few urban areas.

The use of ART to prevent MTCT is one of the most important technological advances in the prevention of HIV. The low cost of Nevirapine, the offers from the pharmaceutical industry to provide the drug free, and the additional funds from the U.S. Government's LIFE initiative have led to the development of new programs for the prevention of MTCT in a few countries. Lack of resources is a major obstacle to widespread access to this intervention.

The most neglected area of HIV/AIDS is access to medical and non-medical care and support services. Most people living with HIV/AIDS do not even have adequate, basic medical care. Despite the fact that in the most severely affected countries, the majority of hospital beds are occupied by terminally ill AIDS patients, most AIDS patients end up dying at home without adequate basic care, palliative care and psycho-social support. Access to drugs for opportunistic infections, or OI, and ART is even more limited. However, access to basic medical care, home-based care, psycho-social support, treatment of TB and palliative care are all affordable and feasible for people living with HIV/AIDS in SSA.

Services and support for children affected by HIV/AIDS is limited in most of Africa. Despite increased funding from the LIFE initiative, resources for services for the vast majority of orphans is grossly inadequate.

In Zambia, FHI, in partnership with several local organizations has initiated a project to Strengthen Community Partnership for the Empowerment of Orphans and Vulnerable Children (SCOPE-OVC). Activities include using participatory techniques to form and strengthen district and community OVC committees and creating technical assistance linkages to micro-finance, community mobilization, and HIV/AIDS prevention initiatives.

I have briefly cited a variety of programs because they have been proven to be effective. However, as effective as these programs are, they all share one serious flaw -- they are simply not reaching all of the people who need the prevention and care that these programs provide. We are not getting to enough people because we do not have enough financial resources and political support. It is as simple as that.

We now need to scale-up our efforts. This is not a casual need. It is an urgent need.

Many of you may be aware that, in July 1999, the Administration launched the \$100 million LIFE initiative to increase U.S. support in sub-Saharan Africa and India. This is a step in the right direction, and we will need more resources such as this so that we can focus more on prevention and care.

By scaling up our programs, I mean that we must develop comprehensive strategies and programs at a national level in a given country. The 4 goals of any comprehensive, large-scale country strategy must be to:

1. Reduce the transmission of HIV;
3. Reduce the rate of morbidity and mortality caused by HIV/AIDS;
5. Improve the quality of life for people living with HIV and AIDS;
7. And, finally, mitigate the impact of the epidemic.

Scaling up by definition means increasing the size and type of activities that have been proven to be effective. It means increasing the geographical areas that are covered and the number of people who are reached. It means improving both the quality and the intensity of programs already in operation.

FHI is aggressively developing scale-up strategies, models, and guidelines for a variety of countries around the world, including in sub-Saharan Africa. These scale-up strategies take a multisectoral approach involving health programs, social programs, and development programs.

These scale-up strategies are designed to build institutional capacity among governments, international PVOs, local NGOs and CBOs, civil society, private industry, and the international donor community.

Conclusion

If I may, I would like to conclude by saying that I recently made a presentation at the Thirteenth International AIDS Conference in Durban, South Africa. The title of my speech was "Prevention Does Work!"

I am sorry to say that the recommendations I made in Durban were almost identical to the recommendations I made 7 years ago at the Ninth International AIDS Conference in Berlin.

The HIV/AIDS pandemic continues its relentless spread, and the response is still woefully inadequate in most countries. More than 5 million people become infected every year, yet denial and discrimination still prevail.

However, our experiences overwhelmingly tell us that success in HIV prevention is achievable.

We need to apply the lessons learned from successful prevention programs to other settings and expand the coverage of these programs.

We need to double our research efforts to find a cure, or at least more effective and affordable therapies, to find vaccines for both AIDS and STDs and to find more effective microbicides.

We also need to improve our understanding of the factors that contribute to the differences between the epidemics in Senegal and the Philippines, where the epidemic remained at a low level, compared with countries in southern Africa where the epidemic has soared beyond predictions.

New and more effective anti-retroviral drugs have reduced AIDS morbidity and mortality and the transmission of HIV from mother to child. They may even have reduced sexual transmission of HIV – but only in industrialized countries. Unfortunately, these drugs are still way beyond the reach of most people in the developing world.

The human race is capable of the greatest acts of kindness and compassion. Yet we spend more resources fighting each other than saving each other. If a nation were to attack a neighboring country and kill 700 people every week, there would be international outrage – especially if that country were in Europe. Yet that's how many people die every week from AIDS in Zimbabwe, a country with a population of only 11 million.

The Western world spent several billion dollars on the wars in Iraq and Kosovo to stop aggression and injustice. Yet we have not provided enough resources to fight an aggressive virus that has already killed more than 16 million people and threatens to kill more people than the two World Wars. African countries with devastating AIDS epidemics and struggling economics also spend their scarce resources on military conflicts, while the real enemy, the HIV epidemic, rages on in their countries.

We know what we need to do. We know that HIV prevention can work. Mr. Chairman, I think you will agree that there is nothing worse than watching an innocent child or mother die a horrible death. Let's do the right thing. Let's work together to save the next generation of children in Sub-Saharan African, and other countries, from HIV/AIDS.

Thank you for inviting me to testify today. Mr. Chairman, please call me anytime.

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Peter Lamptey, M.D., Dr. P.H.
Director, IMPACT Project
Senior Vice President, HIV/AIDS Programs

Dr. Peter Lamptey is the Director of the Implementing AIDS Prevention and Care (IMPACT) Project, based in Arlington, Virginia, which is funded by the United States Agency for International Development (USAID) and implemented by Family Health International (FHI). IMPACT manages HIV/AIDS prevention and care programs in Africa, Asia, Latin America and the Caribbean, and Eastern Europe. Dr. Lamptey is also the Senior Vice President of HIV/AIDS Programs for FHI, an international nongovernmental organization (NGO) based in Research Triangle Park, North Carolina, with more than 12 years of HIV/AIDS programming experience in over 50 countries.

Prior to directing IMPACT, Dr. Lamptey directed the AIDS Control and Prevention (AIDSCAP) Project, funded by USAID (1991-1997) and the AIDS Technical Support (AIDSTECH) Project (1987-1992); both were implemented by FHI. The largest international HIV/AIDS prevention program ever undertaken, AIDSCAP comprised more than 800 projects in 45 countries.

Born in Ghana, Dr. Lamptey received his medical degree from the University of Ghana and holds a master's degree in public health from the University of California, Los Angeles (UCLA), and a doctorate in public health from the Harvard School of Public Health. He was a research fellow in nutrition at the Massachusetts Institute of Technology (MIT) and trained in epidemiology at the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia.

Peter Lamptey is a public health physician and an internationally recognized expert on HIV/AIDS/STI (sexually transmitted infections), with particular emphasis on infectious disease transmission in developing countries. He is the former chair of the Monitoring the AIDS Pandemic (MAP) Network, a global network of more than 100 HIV/AIDS experts in 40 countries, formed in 1996 by AIDSCAP, the François-Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health, and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

Dr. Lamptey has consulted worldwide on HIV/AIDS/STI, nutrition and family planning and was a lecturer on maternal and child health and family planning at the University of Ghana Medical School for ten years and at the University of North Carolina School of Public Health. For more than 15 years, Peter Lamptey has been instrumental in establishing FHI as a leader in family planning and as the world's largest international NGO involved in HIV/AIDS prevention and care. Prior to his international program management and teaching experience, Dr. Lamptey served as a district medical officer in Salaga, Ghana, responsible for health services to some 200,000 individuals and for the USAID-funded Danfa Comprehensive Rural Health Family Planning Project.

U.S. House of Representatives
International Relations Committee
Subcommittee on Africa
Hearing: HIV/AIDS in Africa: Steps to Prevention
September 27, 2000

**Testimony of Ms. Mary Crewe
Director of HIV/AIDS Unit
University of Pretoria**

South Africa still has what has been classified as the fastest growing HIV/AIDS epidemic in the world. It is estimated that 22.4% of pregnant women are currently infected, with close on 1700 new infections per day. These figures are arrived at through the antenatal surveys, which are undertaken in October each year. The antenatal survey is a random unlinked sample testing pregnant women, using state hospitals for HIV infection. In 1990, the infection rate was less than 1%, by 2000 - ten years later it is edging 25%.

South Africa has a unique National AIDS Plan which was developed through extensive government, community, labor, business, religious groups, NGOs and CBO participation. This Plan was endorsed and adopted by the Government in 1994, but to date very little of the plan has been implemented. A new plan - the Strategic Response 2000 - 2005 - was adopted earlier this year - in essence a summarized version of the 1994, National Plan. The National Plan has six key areas for intervention with priority areas in each - Education and Prevention, Counseling, Care, Legal Reforms, Research and Welfare Issues. Had just the priorities been implemented post 1994, the HIV/AIDS situation could have been very different.

The AIDS program is located in the HIV/AIDS and STD directorate in the National Department of Health, and is advised through a national advisory committee and various task teams. In each of the nine provinces there is a similar structure and in some provinces a provincial AIDS council. In effect this means that there are 10 AIDS plans and there has been some degree of tension between the national and provincial programs.

There have been many attempts to deal with the epidemic, post 1994, building on the foundations that were to some extent laid by the previous regime. These range from the life skills programs in state primary and secondary schools, which is a joint program between the national and provincial departments of health and education, to the training of health care workers in STD treatment and general counseling skills and a variety of AIDS awareness campaigns. There is also fairly extensive funding for NGO's, though it is less now than it has been in previous years.

Something of a paradox exists in South Africa with a very HIV/AIDS aware population but one in which very high levels of stigma, prejudice and denial exist. The awareness has not been translated into any significant or sustained behavior change nor into great community mobilization to get involved and campaign for an AIDS free country.

The role of the government has of late, been controversial. The debates that have been conducted between the government, media and various community groups, have done two things - they have raised the profile of HIV/AIDS in the public consciousness and have created some debate about the impact of HIV on South African development. However, the linking of AIDS to poverty as the causal agent, and the questioning of HIV as the cause of AIDS, has caused some confusion and a reluctance to admit that behavior change is crucial.

As with previous campaigns or programs that have been controversial, such as Sarafina 2, the AIDS Play and Virodene, the AIDS 'cure', this has served in some ways to deflect the urgency away from the need to intensify prevention and care services.

For most people working in HIV and AIDS service organizations, research centers, hospitals and clinics the belief is that it is business as usual and that the campaigns for prevention and care should not be affected and that the debates can give extra impetus to their work. The debates have caused some people to question the validity of HIV testing or acceptance of the fact that HIV was sexually transmitted. The political tensions that arise from the reluctance to be seen to be challenging the official line, has affected AIDS work in a variety of ways and to some extent AIDS work has been set back.

AIDS workers have, however, always had to deal with high levels of doubt and denial and this confusion has allowed for a new take on how best AIDS education should be given, and issues in HIV/AIDS debated.

There are still areas of great concern in the HIV/AIDS situation in South Africa, despite the programs that exist. One is the ability of communities to cope with the demands of care and support within very poor and deprived areas and in areas in which there are few services providing water, power or housing. There are few policies, which offer guidelines on crucial aspects of the transmission of HIV - we await decisions on the use of drugs in MTCT, as well as on the controlled use of anti-retrovirals. There also needs to be a careful decision on the provision of drugs in the absence of a real support infrastructure. Access to drugs is a highly charged issue, as is the question of compulsory licensing and parallel imports.

There is no formal policy on breast-feeding or on voluntary counseling and testing. There are draft policies, but they have not been implemented. There is no policy on the care for families and particularly for the care of orphans. It is quite clear that the so-called extended families will not be able to cope with the levels of care and support required. Apartheid policies destroyed many families and the extended family structure is fragile and vulnerable to the effects of poverty and HIV/AIDS. Asking already over-extended families to take in orphans who have been traumatized and are in need of counseling and support threatens the viability of many families as well as the life chances of all the young people in the family. Clearly where families can cope this would be the ideal, but where not, creative alternatives must be sought.

There is no policy on support for care givers and no real understanding what the impact of home based care will be, particularly in areas where there are no real homes. If poverty does make people more vulnerable to the risk of HIV infection, then policies that contribute to poverty must

be resisted. There seems to be even at policy level an indecision and a lack of political will to act in decisive and bold ways to start to mitigate the effects of HIV and AIDS on individuals, households, and communities.

But there is much that is happening through local authority and provincial structures as well as in communities through NGOs and CBOs. There are home based care programs, and there is the exciting potential of the development of a home based care kit (through the University of Pretoria and the National Department of Health) that is likely to transform care in most communities. There are support services, food aid as well as community education and awareness and income generating projects. In the main these are uncoordinated and remain inadequate for the needs of the country and the demands of the epidemic will soon far outstrip the programs and services available.

The school-based program is being expanded and there are increasing interventions aimed at youth in both school and tertiary institutions, as well as looking at ways to integrate youth not in school.

The picture is very bleak at the moment, in terms of the rate of infection, the high levels of prejudice, discrimination and denial and the paucity of services, support and care. However, as a discussion hosted on behalf of the AAI showed - involving a range of key stakeholders and role-players - it is by no means hopeless. There is still time to turn the epidemic around, there is still time to make an enormous impact in prevention and care and still time to re think the policies and programs especially with regards to orphans, families and communities in distress and most at risk.

But this requires new and creative vision, new ways of addressing the socio-economic and political questions and a new understanding of what is possible in this epidemic and how best the society and country can hope to come through it.

Durban 2000 did energize the country and it is important to sustain that momentum - there is a great deal of concern in the general population about HIV and AIDS. This needs to be channeled into actions that really will make a difference rather than looking at more of the same. We need to adopt a positive stance on HIV and AIDS to show people that we can take what is positive from this epidemic to strengthen relationships, families and communities. To transform the education and health systems so that they are better able to deal with the multiple demands of such an epidemic. To refocus the welfare department in how it gives support and to energize the state to act decisively and with leadership and vision, so that we not only live through the epidemic but that we emerge from it, stronger, united and with an intact social and political structure.

MARY CREWE

Ms. Crewe is the chairperson of the National Committee for School Based HIV/AIDS Education. She has published extensively in the field. She is also the author of the book *AIDS in South Africa: The Myth and Reality*.

Testimony of Representative Barbara Lee: Durban Report
Africa Subcommittee
September 27, 2000

SUMMARY OF FINDINGS:

Overview of HIV / AIDS in sub-Saharan Africa

According to a recent report by the World Health Organization, 23 million people are infected with the HIV virus in sub-Saharan Africa, with new infections coming at the rate of roughly 5,000 a day. Of the 13 million HIV-related deaths reported to date, 11 million have been in sub-Saharan Africa. HIV-AIDS kills ten times more people in sub-Saharan Africa annually - more than 2.6 million last year alone - than all of the continent's armed conflicts combined.

- South Africa has been particularly hard hit. Some 1,600 South Africans are being infected every day. With nearly one of every five South African adults infected with HIV, this country of 41 million people has more people living with HIV than any other.
- Not since the bubonic plague ravaged Europe in the Middle Ages has there been as devastating a disease. More than 16 million people have died from AIDS since the 1980s, 60 percent of them in sub-Saharan Africa.
- Few issues are as threatening to global prosperity, security and development. HIV/ AIDS has not only taken a devastating toll on the productive sectors of society; it has also

- Furthermore, HIV / AIDS is creating an "orphan crisis" of epic proportions. Some 13.2 million children under 15 have been orphaned by AIDS, 95% of them in Africa. (UNAIDS 1998) To date, there are over 7.8 million AIDS orphans in sub-Saharan Africa alone. (UNAIDS 1998) To many experts, AIDS orphans represent a lost generation of desocialized youth, a potential reserve for militias and therefore a potential source of political instability.
- According to a study released by USAID during the XIII International AIDS Conference, ten years from now, one in seven children under 15 in sub-Saharan Africa will have lost a parent. By 2010, it is predicted that 8 percent of black African children, or approximately 21.8 million, will be orphans, with AIDS as the reason in 70 percent of cases. If losing just a father also fits the definition of "orphan" - as many demographers believe it should - the total will reach 44 million, with AIDS again as the primary cause. (USAID, July 2000)
- The commercial effects of the epidemic are also significant. With respect to international business, the devastating effects of the disease translate into higher labor costs, reduced productivity, a contracting labor pool, reduced demand and purchasing power, less growth and profitability. HIV / AIDS inhibits private sector growth and leads to wider and deeper poverty.
- HIV / AIDS is also believed to pose a direct threat to global security. In January, 2000, Vice President Al Gore convened the first Security Council session to address HIV / AIDS as a global security threat. A report by the CIA on the global infectious disease threat cites dramatic declines in life expectancy as the strongest risk factor for "revolutionary wars, ethnic wars, genocides and disruptive regime transitions" in the developing world. According to this report, the social consequences of AIDS appear to have a "particularly strong correlation with the likelihood of state failure in partial democracies." [CIA, 1999] It is widely believed that the spread of AIDS will challenge democratic development and transitions and possibly contribute to humanitarian emergencies and military conflicts to which the United States may need to respond.

Specific Conference Outcomes

The following items represent a summary of the key scientific, political and social developments that emerged during the XIIIth International AIDS Conference:

On the scientific front, regrettably, the most significant scientific development emerged as a setback to many researchers and experts, who had hoped to find an effective method for women to protect themselves against transmission during intercourse.

- **Female-Controlled Microbicides.** Marking one of the conference's most significant scientific setbacks, researchers disclosed results of a study testing the efficacy of a Nonoxynol-9-based microbicide gel in preventing transmission of HIV. The vaginal gel, widely heralded as a way for women to protect themselves without relying on their male partners to use condoms, not only failed to prevent HIV-transmission, but in many cases, actually facilitated transmission by causing genital tearing and ulcers. The study, which involved 990 prostitutes in four African and

two Asian cities, ended hopes that Nonoxynol-9 could serve an important role in the battle against HIV. According to researchers, a half-dozen other compounds are currently under study as vaginal microbicides.

- **Access to Prescription Drugs.** One of the overarching themes at the conference was the issue of access to prescription drugs. Since their emergence in Western countries five years ago, anti-retroviral therapy treatments have been largely successful at prolonging the lives of persons living with HIV / AIDS in the industrialized world. However, due to their high cost --as much as \$12,000 annually - an amount that exceeds the annual income of more than three-quarters of South African households-the possibility of administering anti-retroviral therapies in the developing world has been largely discounted by policymakers as impractical. In addition to carrying a hefty price tag, it has been widely accepted that these drugs also require a sophisticated health infrastructure in order to be properly administered.

A study released at the Conference, however, appeared to challenge these assumptions. Results of three small experiments in the capitals of Cote D'Ivoire, Senegal and Uganda seem to suggest that combination therapies may in fact prove usable for larger, poorer AIDS-infected populations in many Third World cities. In these cases, when administering the therapies to fewer than 1,000 patients, researchers reported significant success, despite the rudimentary health systems in place.

The tests offered new hope towards overcoming the gulf that has traditionally separated medical care between rich and poor countries. At the same time, participants were cautioned against drawing far-reaching conclusions from this study, due to the small scale on which it was performed.

- **Mother-to-Child Transmission.** One of the more contentious topics at the outset of the Conference concerned the issue of mother-to-child, or peri-natal transmission.

Preventing peri-natal, or mother-to-child transmission has been highlighted by policymakers and AIDS activists worldwide as a key priority for societies to slow the spread of the disease. Studies suggest that as many as one-third of infants become infected with HIV when mothers who breast-feed are not given anti-viral drugs at the time of delivery.

The effectiveness of drugs like AZT and Nevirapine, designed to prevent peri-natal transmission, have been widely debated. Many researchers had discounted their benefits, arguing that any baby saved by the treatment, would likely still risk infection through the mother's breast-milk.

But most studies released at the International AIDS Conference show that when the mother is given the drug Nevirapine at the time of delivery, a large number of babies remain uninfected well into the breast-feeding stage. These conclusions led many to assert that mother-to-child transmission can be reduced anywhere in the world for relatively small amounts of money.

This development is particularly significant for South Africa, where health officials had specifically questioned the effectiveness of drugs like Nevirapine, on the grounds that it could in fact be potentially toxic and pose a health risk to pregnant women.

Although Nevirapine's maker, the German pharmaceutical manufacturer Boehringer Ingelheim announced days before the Conference that it is prepared to give the drug away for free, developing countries must still decide whether to invest their budgets in the infrastructure needed to deliver the drug to women.

